

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11773

CERTIFICATE OF DEATH

Reg. Dist. No. 117654

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED: (Type or Print)		(First) John Wesley Anderson	(Last)
5. SEX: M		6. COLOR OR (RACE): Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Unk -	8. DATE OF BIRTH: 3-2-1862
10c. AGE last birthday: 93		9. DATE OF DEATH: Dec. 31	10. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME: John Anderson		11. BIRTHPLACE (State or foreign country): Md	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
(Yes, no, or unk.)		(If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: 44-3X		17. INFORMANT & ADDRESS: Martha Slagars Linville Johnson - Sykesville, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
44-3X Immediate cause (a) arteriosclerotic cardiovascular disease			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) hypertension; endarteritis obliterans, etc; (c) ch. myocardiis; — senility			
Interval Between Onset And Death 20+ yrs			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from 1935, 19, to 31 Dec, 1955, that I last saw the deceased alive on 30 Dec, 1955, and that death occurred at 12:25 P.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED 12/31/55			
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF 1-3-'56	NAME OF CEMETERY OR CHAMBERS St. Luke's
DATE REC'D BY LOCAL REGISTRAR Jan. 2, 1956		REGISTRAR'S SIGNATURE C. Harry Allen	LOCATION (City, town, or county) (State) Sykesville, Carroll, Md.
24. FUNERAL DIRECTOR		ADDRESS	
Guthrie A. Height, Sykesville, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

11766

STATE DEPARTMENT OF HEALTH

MARYLAND

11774

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH
COUNTY

Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL and
OR give nearest town) LENGTH OF STAY
TOWN *Finksburg* (in this place)
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS *Deer Park Rd.*

3. NAME OF
DECEASED
(First) (Middle)

Lee

Milford

4. DATE
OF
DEATH

(Month) (Day) (Year)

5. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)*Hetley Enginer*

13. FATHER'S NAME

*Abraham Lincoln*7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify)

Married

10b. KIND OF BUSINESS OR
INDUSTRY*March 17 1893*

8. DATE OF BIRTH

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?*Kansas**U.S.A.*

14. MOTHER'S MAIDEN NAME

*Mary Chilcoat*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)*No*

16. SOCIAL SECURITY NO.

176-65-3167

17. INFORMANT AND ADDRESS

George Bailey, RFD #1, Finksburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

*156.1**Immediate cause (a) *Carcinoma, liver***Antecedent cause(s) (b) _____**Diseases or conditions, if any, giving rise to the above cause**stating the underlying cause last**(c) _____*

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not
related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT (Specify)

SUICIDE

HOMICIDE

INJURY

PLACE (Home, farm, factory, street,
of office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY

While at Work At work

How did injury occur?

m. While at Work At work

5:30 A.M.

ADDRESS

DATE SIGNED

SIGNATURE

Degree or title

ADDRESS

DATE SIGNED

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

22. I hereby certify that I attended the deceased from *Sept. 8*, 1955, to *Dec. 2*, 1955, that I last saw the deceasedalive on *Dec. 2*, 1955, and that death occurred at *5:30 A.M.* from the causes and on the date stated above.

ADDRESS

DATE SIGNED

Signature *Clarence E. McWilliam M.D.*

Furnituretown Maryland Dec 2 1955

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

23. BURIAL, CREMATION DATE

REMOVAL (Specify)

NAME OF FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

REG. *12-3-55*

J. Eline & Sons Furnituretown, Md.

Faifield Pa.

BUREAU V. S.

DEC 6 1935

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**CERTIFICATE OF DEATH**

11767

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Md. COUNTY Baltimore City (If rural give location)	
X Carroll Sykesville		since 7-25-52		Baltimore City		3101-4 523 S. Kenwood Ave	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hosp.				STREET ADDRESS			
3. NAME OF DECEASED (First) Anna (Middle) Marie (Last) Baldwin				4. DATE OF DEATH Dec. 25 1955			
S. SEX fem.	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) mar.	8. DATE OF BIRTH 4-12-1890	9. AGE last birthday 65 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUSEL WORKS				10b. KIND OF BUSINESS OR INDUSTRY AT HOME,			
13. FATHER'S NAME James Ross				11. BIRTHPLACE (State or foreign country) Maryland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				14. MOTHER'S MAIDEN NAME Florence Bishop			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS records of Springfield State Hosp.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334 X IMMEDIATE CAUSE (A) Chronic brain syndrome associated with ANTECEDENT CAUSE(S) DUE TO circulatory disturbance, cerebral arteriosclerosis DISEASES OR CONDITIONS, IF ANY, (B) with psychotic reaction. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
more than 10 years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. diabetes 3 yrs							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from July 25, 1952, to Dec. 25, 1955, that I last saw the deceased alive on Dec. 25, 1955, and that death occurred at 8:17 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Martin Gross, M.D.</i>				ADDRESS (Street, city, town, state) Martin Gross, M.D. Sykesville, Md.			
DATE SIGNED Dec. 26, 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-29-55		NAME OF CEMETERY OR CREMATORIUM OAK LAWN CEM.		LOCATION (City, town, or county) 7225 EASTERN BLVD., MD.	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE C. Harry Weisz DATE DEC 27 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 901 S. CONKLING ST. BALTIMORE 24, MD.					

STATION TO STATE STATION

STATE TO STATE

ALL INFORMATION

RECEIVED FROM THE

ALL INFORMATION

BUREAU V. S.

DEC 28 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1176?

CERTIFICATE OF DEATH

12555

76

Reg. Dist. No.....

1. PLACE OF DEATHCOUNTY **CARROLL**CITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN **WESTMINSTER**HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

165 E. GREEN

MARYLAND

LENGTH OF STAY
(in this place)

13 YRS.

2. USUAL RESIDENCE (HOME) OF DECEASEDSTATE **MD.**COUNTY **CARROLL**CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNSTREET
ADDRESSWESTMINSTER
(If rural give location)

165 E. GREEN

3. NAME OF

(First)

(Middle)

(Last)

(Type or Print)

JOSEPH HENRY BANGE**4. DATE**

(Month)

(Day)

(Year)

OF
DEATH**DEC. 31 1955****5. SEX****M****6. COLOR OR
RACE****W****7. SINGLE, MARRIED,
WIDOWED, DIVORCED,****MARRIED****8. DATE OF BIRTH****OCT. 21-1877****9. AGE last birthday****78 yrs.****IF UNDER 1 YEAR****Months****IF UNDER 24 HRS.****Days****Hours****Min.****10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)****RAT FARMER****10b. KIND OF BUSINESS
OR INDUSTRY****11. BIRTHPLACE (State or Foreign country)****MD.****12. CITIZEN OF WHAT
COUNTRY?****U.S.A.****13. FATHER'S NAME****SIMON BANGE****14. MOTHER'S MAIDEN NAME****NOT KNOWN****15. WAS DECEASED EVER IN U. S. ARMED FORCES?****NO**

(Yes, No, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.**219-03-7501****17. INFORMANT & ADDRESS****DAISY BANGE 165 E. Green
Westminster, Md.****I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****442X IMMEDIATE CAUSE****(A)****Cardiovascular Disease 1955**

ANTECEDENT CAUSE(S) DUE TO

(B)**with myocardial degeneration**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE

(C)**Arteriosclerosis & mild**

STATING UNDERLYING CAUSE LAST.

general**II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.****Fatty liver & prostate****Feb 11-1954****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION**ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)WHERE DID INJURY OCCUR? (City or town)
(County) (State)**21d. TIME OF INJURY (Month) (Day) (Year) (Hour)****21e. INJURY OCCURRED****21f. HOW DID INJURY OCCUR?**White Not while
M. at work of work**22. I hereby certify that I attended the deceased from****alive on Dec 31, 1955, to Dec 31, 1955, that death occurred at 11:45P.M. from the causes and on the date stated above.****SIGNATURE****William Speciale M.D.****ADDRESS (Street, city, town, state)****DATE SIGNED****1/2/56****23. BURIAL / CREMATION,
REMOVAL (SPECIFY)****BURIAL****DATE THEREOF****JAN 4, 1956****NAME OF CEMETERY OR CREMATORIUM****DEER PARK CEM. REISTERSTOWN, MD.****LOCATION (City, town, or county)****(State)****24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE****25. FUNERAL DIRECTOR'S SIGNATURE****ADDRESS****DATE 1-6-56****Hannit Muller 413 Lombard St Westminster, Md.**

THE ASSASSINATION OF MARTIN LUTHER KING

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1968

RECEIVED

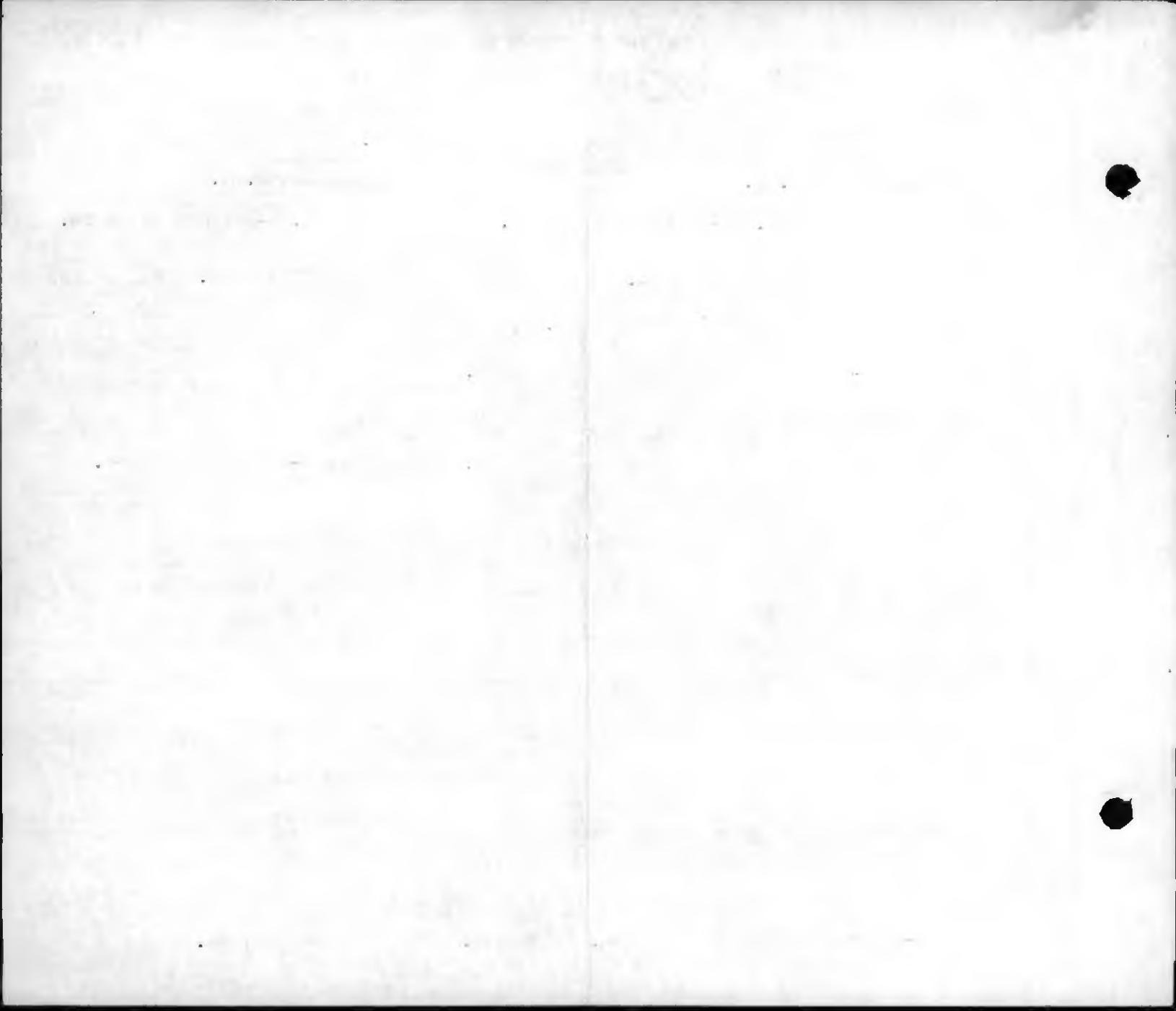
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11768
74

11776 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Sykesville P. O.				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville P. O.				
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route No. 1 - Oakland Mills Rd.				STREET ADDRESS (If rural give location) Route No. 1-Oakland Mills Rd.				
3. NAME OF DECEASED: (Type or Print)		(First) ANNIE	(Middle) E.	(Last) BARNEY	4. DATE (Month) (Day) (Year) OF DEATH: Dec. 27, 1955			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed	8. DATE OF BIRTH: Nov. 7, 1863	9. AGE last birthday: 92 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Va.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: James Sanders				14. MOTHER'S MAIDEN NAME: Rebecca Todd				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Mrs. Ruth Gisburne-Oakland Mills Rd.				
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.								INTERVAL BETWEEN ONSET AND DEATH
(A) Due to Cardio-vascular Disease (B) Due to Arteriosclerosis + Hypertension (C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from 12/26/1955, to 12/27/1955, that I last saw the deceased alive on 12/26/1955, 1955, and that death occurred at 12/27/1955, M., from the causes and on the date stated above. SIGNATURE: <i>Jean E. Martin</i> ADDRESS: M. D. <i>Bouldallerton Md</i> DATE SIGNED: 12/27/1955								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-removal		DATE THEREOF 12/27/55		NAME OF CEMETERY OR CREMATORIUM St. Johns Cem.		LOCATION (City, town, or county) Hampton, Va. (State)		
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <i>Wm. J. Tickner & Sons</i>		ADDRESS <i>Baltimore Md.</i>		



11769

MARYLAND STATE DEPARTMENT OF HEALTH

1177?

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

70
80

1. PLACE OF DEATH: COUNTY <u>CARROLL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TANEYTOWN</u> RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET (If rural, give location) ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) <u>BETTY</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>BAUER LIEN</u>
4. DATE OF DEATH	(Month) <u>OCT</u>	(Day) <u>12</u>	(Year) <u>1955</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH
<u>F</u>			<u>MAY 10-1932</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<u>Singer in church</u>	<u>Church music</u>	<u>MARYLAND</u>	<u>USA</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<u>GEORGE MOSER</u>	<u>HELEN GRIMES</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT	18. MEDICAL CERTIFICATION
	<u>220-28-7968</u>	<u>HELEN MOSER - 000-5000 RURAL</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause	(a) <u>Gunshot wound head and chest</u> Minutes		
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(b)			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office, bldg., etc.) INJURY <u>None</u>	(CITY OR TOWN) <u>Rune Taneytown</u>	(COUNTY) <u>Carroll</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 12 1955</u>	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Shot in Head and Chest with rifle</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> theron and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James J. Moran, Deputy Medical Examiner Carroll</u>	(Degree or title) <u>Address</u>	DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF <u>Oct 15-1955</u>	NAME OF CEMETERY OR CREMATORIAL <u>Carroll Cemetery</u>	LOCATION (City, town, or county) <u>Carroll</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE <u>Ethel M. Mehling</u>	24. FUNERAL DIRECTOR <u>Funeral & Mortuary Services, Inc.</u>	ADDRESS
<u>Oct 14/55</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11770

CERTIFICATE OF DEATH

Reg. Dist. No.... 26

11768
Iter. 2, Film #91 12-3-56 et.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Carroll Co.</i>	MARYLAND <i>Length of stay (in this place)</i> <i>Westminster, Md.</i>	STATE <i>Maryland</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Westminster</i>	TOWN <i>Westminster</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Md.</i>	OR TOWN <i>Westminster, Md.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Center St (Elm Morning Lane)</i>		STREET ADDRESS <i>Pennsylvania Avenue</i>	IF Rural, give location <i>(Westminster, Md.)</i>
3. NAME OF DECEASED (Type or Print) <i>EMMA JANE BAUST</i>		4. DATE OF DEATH <i>Dec 19 1955</i>	
S. SEX <i>f.</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>16 March 1867 88</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Carroll Co., Md.</i>
13. FATHER'S NAME <i>David H. Warden</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Reagle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>140-31-1000</i>	
17. INFORMANT & ADDRESS <i>Harriet Miller, postman</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>331X</i>		IMMEDIATE CAUSE <i>Cerebral Hemorrhage</i>	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO <i>Hypertension & arteriosclerosis</i>	
		DUE TO <i>Valvular Heart Disease</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21f. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21g. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Dec 11-1955</i> , 1955, to <i>Dec 19, 1955</i> , that I last saw the deceased alive on <i>Dec 19, 1955</i> , and that death occurred at <i>5:15 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>W. Edmund Speicher, M.D.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Dec. 22, 55</i>	
24. REC'D BY REGISTRAR <i>Carroll</i>		NAME OF CEMETERY OR CREMATORIUM <i>Westminster Cemetery</i>	
REGISTRAR'S SIGNATURE <i>Harriet Miller</i>		LOCATION (City, town, or county) (State) <i>Westminster, Md.</i>	
DATE <i>12-21-1955</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. E. Myers, Jr., Westminster, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10/W

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11771

11778 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Rural - Sykesville		since 8-8-55		OR TOWN Monrovia		STREET ADDRESS Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				(If rural give location)			
3. NAME OF DECEASED (First) Windsor				4. DATE OF DEATH Dec. 13th 1955			
(Middle)		(Last) BEALL		AGE last birthday 72 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH May 5, 1883	9. 10. BIRTHPLACE (State or foreign country) Monrovia, Maryland	11. COUNTRY United States		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry		12. CITIZEN OF WHAT COUNTRY United States			
13. FATHER'S NAME Caleb A. Beall				14. MOTHER'S MAIDEN NAME Margaret L. Watkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Records of Springfield State Hospital			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Bronchopneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis (C) —				more than 10 years			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis with				more than 10 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION psychotic reaction.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 10, 1955, to Dec. 13, 1955, that I last saw the deceased alive on Dec. 13, 1955, and that death occurred at 2:50 P.M. from the causes and on the date stated above. SIGNATURE <i>R. L. Klemm</i> M.D. ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12-13-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 16, 1955		NAME OF CEMETERY OR CREMATORIUM Bethesda Cemetery		LOCATION (City, town, or county) Browningsville, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE C. Henry Miller		25. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobley		ADDRESS Damascus, Md.	
DATE Dec. 16, 1955							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11772

11779 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Carroll MARYLAND Rural Manchester Md Life	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland COUNTY Carroll Rural, Manchester Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Manchester, Westminster Rd	STREET ADDRESS (If rural give location)	Manchester, Westminster Rd
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print)	George Peter Bifler		
4. DATE (Month) (Day) (Year) OF DEATH Dec 19 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Wednesday Jan 5 1862
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Peter Bifler		14. MOTHER'S MAIDEN NAME Priscilla Mathias	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Earl Wentz, Westminster Rd		18. MEDICAL CERTIFICATION Chronic myocarditis Arterio-sclerotic Cardiovascular Disease ?	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Chronic myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____	
M.		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1948, to Dec 18, 1955, that I last saw the deceased alive on Dec 15, 1955, and that death occurred at 11 A.M. from the causes and on the date stated above.			
SIGNATURE Joseph Bush		ADDRESS (Street, city, town, state) Hampstead Rd	
DATE SIGNED Dec 19 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE (Month) (Day) (Year) 12/22/55	NAME OF CEMETERY OR Crematory Baltimore	LOCATION (City, town, or county) Manchester, Md
24. REC'D BY REGISTRAR Date Dec 21-55	REGISTRAR'S SIGNATURE Mrs. W.P. Denner		
25. FUNERAL DIRECTOR'S SIGNATURE Frederick, Buckley, Hanover P.		ADDRESS	

BUREAU

DEC 28 1955

REGISTRATION

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11773

11780 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <input checked="" type="checkbox"/> TOWN	Carroll	MARYLAND	STATE <input checked="" type="checkbox"/> TOWN	Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> Rural - Sykesville		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		
7 Mos. 26 days			(If rural give location)		
15. INSTITUTION OR STREET ADDRESS Springfield State Hospital			3316 Harmony Court		
3. NAME OF DECEASED (First) Felicia (Middle) (Last) BOONE			4. DATE OF DEATH (Month) (Day) (Year) 12 4 1955		
5. SEX <input checked="" type="checkbox"/> F	6. COLOR OR RACE <input checked="" type="checkbox"/> W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 2/7/88	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/> none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Cuba		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> alien
13. FATHER'S NAME Phillip			14. MOTHER'S MAIDEN NAME Ella		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Record, Springfield State Hospital		
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 2 days.		
1 IMMEDIATE CAUSE <input checked="" type="checkbox"/> Bronchopneumonia		DUE TO (A)	years		
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <input checked="" type="checkbox"/> Diabetes Mellitus		DUE TO (B)			
(C)		DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease, with psychotic reaction			2 - 3 years		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 10/21, 1955, to 12/4, 1955, that I last saw the deceased alive on 12/3, 1955, and that death occurred at 2:50 A.M. from the causes and on the date stated above.					
SIGNATURE Walter H. Somerville M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/6/55	NAME OF CEMETERY OR CREMATORIAL Faith & Sean Bernau & Lee Rd		LOCATION (City, town, or county) (State)
24. REC'D BY REGISTRAR DATE 1960		REGISTRAR'S SIGNATURE C. Barry Davis	25. FUNERAL DIRECTOR'S SIGNATURE D. J. Gabay, Son		

3 A

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11774

11781 CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2, FilmG190 12-28-55 et

1. PLACE OF DEATH

COUNTY Carroll

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Rural - Sykesville

MARYLAND

LENGTH OF STAY
(in this place)

since 11-14-52

2. USUAL RESIDENCE (HOME) OF DECEASED

Maryland ?

STATE _____

COUNTY _____

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN

Baltimore ?

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Springfield State Hospital

STREET
ADDRESS

Unknown (If rural give location)

Found wandering in streets of Balto.

**3. NAME OF
DECEASED**
(Type or Print)

Walker

(First) (Middle) (Last)

BOONE

AGE last birthday

about 63 yrs.

IF UNDER 1 YEAR

Months Dey Hours Min.

5. SEX

6. COLOR OR
RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) unknown

8. DATE OF BIRTH

unknown

9. AGE last birthday

about 63 yrs.

10. IF UNDER 24 HRS.

Months Dey Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

unknown

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

unknown

12. CITIZEN OF WHAT
COUNTRY?

unknown

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

unkn.

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT & ADDRESS

Records of Springfield State Hospital

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) Coronary occlusion

minutes

ANTECEDENT CAUSE(S)
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DUE TO

(B) Generalized arteriosclerosis

more than
10 yrs.

DUE TO

(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.CBS assoc. with circulatory disturbance, with
cerebral arteriosclerosis, with psychotic reaction.more than
10 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. Not white
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 22 1953, to Dec. 13th 1955, that I last saw the deceased

alive on Dec. 13, 1955, and that death occurred at 1:00 P.M. from the causes and on the date stated above.
SIGNATURE *H. Walker* ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/13/5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Embalmed & stored

DATE THEREOF

12/14/55

NAME OF CEMETERY OR CREMATORIUM

Chap. of Md. Med. School

LOCATION (City, town, or county)

(State)

Baltimore, Md

24. REC'D BY REGISTRAR

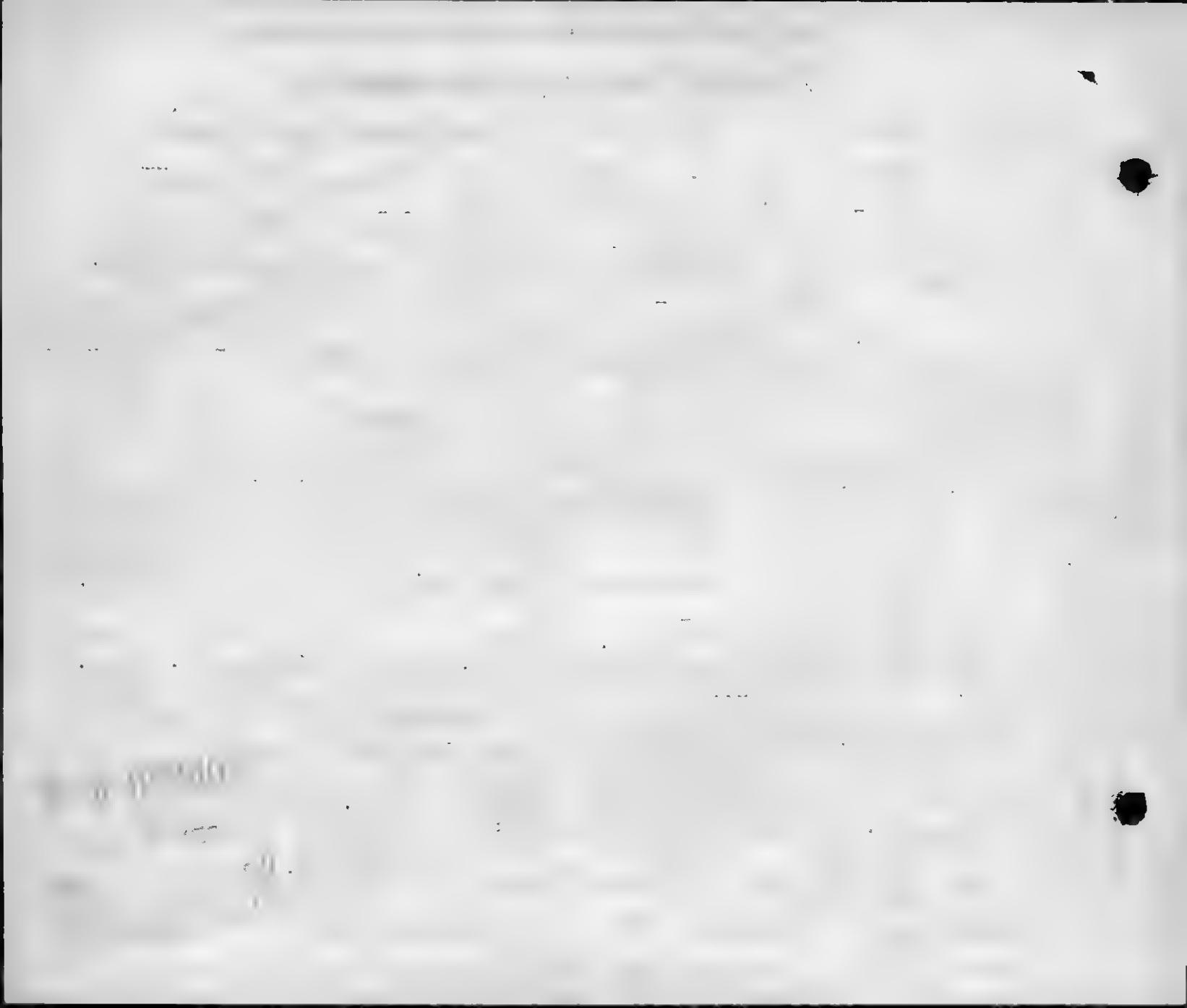
REGISTRAR'S SIGNATURE

Harry Hays

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 12/13/55



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 15-510W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11775

11782

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Henryton		7		OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Henryton State Hospital		STREET ADDRESS		3130 Belmont Avenue		(If rural give location)	
				3. NAME OF DECEASED (Type or Print) Phillip			
(First) (Middle) (Last)				4. DATE OF DEATH 12 10 1955			
S. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 10-31-15	9. AGE at birthday 40 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	(Year) Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Deceased			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) Cardiac insufficiency decompensated							
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary tuberculosis, chronic							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Henryton, Md. (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from... Dec. 3, 1955, to Dec. 10, 1955, that I last saw the deceased alive on Dec. 10, 1955, and that death occurred at 12:35 P.M. from the causes and on the date stated above.							
SIGNATURE T. L. Edel M.D. DATE SIGNED 12-10-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE 12-10-55		REGISTRAR'S SIGNATURE Albert R. Frankham		25. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home 1631 ADDRESS Dund Hill			

UNITED STATES

DEC 15

KEEVIE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11776

11783 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Rural - Sykesville		LENGTH OF STAY (in this place) 9 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore		3 Yrs. 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital		STREET ADDRESS 512 Park Avenue		(If rural give location)			
3. NAME OF DECEASED (Type or Print) DANIEL PATRICK BROWN				4. DATE OF DEATH 12 10 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Div.	8. DATE OF BIRTH 5/21/84	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parking attendant			10b. KIND OF BUSINESS OR INDUSTRY Unk -	11. BIRTHPLACE (State or foreign country) Wisconsin	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Patrick Brown				14. MOTHER'S MAIDEN NAME Eleanor O'Hare			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 211-20-7559			
17. INFORMANT & ADDRESS Record, Springfield State Hospital							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 5 years			
IMMEDIATE CAUSE Arteriosclerotic heart disease				ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Syphilis, undiagnosed site			
DUE TO (A)				DUE TO (B)			
Pulmonary tuberculosis, far-advanced				DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction				5 years			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
19c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
M.				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/1, 1955, to 12/10, 1955, that I last saw the deceased alive on 12/10, 1955, and that death occurred at 1:55 P.M. from the causes and on the date stated above. SIGNATURE <i>Dr. Frank J. Kelly, M.D.</i>							
				ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/10/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-16-55		NAME OF CEMETERY OR CREMATORIUM New Cathedral		LOCATION (City, town, or county) Baltimore, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE C. Harry Teller		25. FUNERAL DIRECTOR'S SIGNATURE A. W. Meeks - 805 N. Calvert St.		ADDRESS	
DATE DEC 15, 1955							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11777

11784

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Rural - Sykesville		CARROLL MARYLAND LENGTH OF STAY (In this place) 16 days		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 11		COUNTY (If rural give location) STREET ADDRESS 2910 Huntington Avenue	
15 STREET ADDRESS Springfield State Hospital							
3. NAME OF DECEASED (Type or Print) CHARLOTTE AGNES BYUS				4. DATE OF DEATH 12 1 19 55			
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 12/20/89	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Deys Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator			10b. KIND OF BUSINESS OR INDUSTRY Noxema Company	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel O'Connor				14. MOTHER'S MAIDEN NAME Margaret O'Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 265-13-4206	17. INFORMANT & ADDRESS Record, Springfield State Hospital		
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Pulmonary embolism ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Arteriosclerotic heart disease (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Carcinoma of left breast Involutional psychotic reaction				INTERVAL BETWEEN ONSET AND DEATH 2 days years			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/28 1955, to 12/1 19 55, that I last saw the deceased alive on 12/1 19 55, and that death occurred at 9:20 PM. From the causes and on the date stated above.							
SIGNATURE <i>Walter H. Sonnenfeld</i> M.D. ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/2/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-5-55	NAME OF CEMETERY OR CREMATORIAL WESTERN		LOCATION (City, town, or county) BALTIMORE MD		
24. REC'D. BY REGISTRAR REG. DATE 12-5-55		REGISTRAR'S SIGNATURE <i>C. Harry Keay</i>		25. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab 2101 Frederick		ADDRESS	

8

EC 1025

REF ID: A6512

11785

11778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 7

1. PLACE OF DEATH: Springfield State Hospital
COUNTY, Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Near Sykesville, Maryland LENGTH OF STAY
(In this place)
Visit

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
None

3. NAME OF
DECEASED:
(Type or Print) Joseph Edward Carew

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN Baltimore 27

STREET
ADDRESS
(If rural, give location)

5610 Carville Avenue

4. DATE (Month) (Day) (Year)
OF DEATH 12 7 1955

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED,
Male RACE: WIDOWED, DIVORCED,
White (Specify): Married Nov. 25, 1882 8. DATE OF BIRTH:
9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
73 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): retired 10b. KIND OF BUSINESS OR INDUSTRY: Waterman

11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?
Maryland USA

13. FATHER'S NAME:

Joseph Carew

14. MOTHER'S MAIDEN NAME:

Martha Schible

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.:
(Yes, no, or unk.) (If Yes, give war or dates of yes World War I 217-141295

17. INFORMANT & ADDRESS:

Mrs. Velma Pritchett, daughter

5610 Carville Ave., Maryland, Belto. 27.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
423.1
Immediate cause (a) Acute Coronary Occlusion
DUE TO

INTERVAL BETWEEN
ONSET AND DEATH
10 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating underlying cause last (b) Myocardial Infarction
DUE TO (c)

3 years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes No

21a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING 21b. PLACE (Home, farm, factory, of street, office bldg., etc.)
CAUSE OF DEATH. INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED
OF INJURY While at Not while
M. work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause
SIGNATURE

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED
12/7/55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
REMOVAL (Specify): Burial 12-10-55 Loudon Park Baltimore

24. FUNERAL DIRECTOR ADDRESS
REG. Howard H. Hubbard, 4107 Wilkens Ave
REG. 12-8-53



11779

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11786 CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH: COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL, OR, and give nearest town) <u>Rural - Sykesville</u>		MARYLAND LENGTH OF STAY (in this place) <u>22 yrs</u>	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Sykesville</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Walter</u>	(Middle) <u>E</u>	(Last) <u>Chenowith</u>	4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 23, 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>12-22-1902</u>	9. AGE last birthday IF UNDER 1 YEAR 53 yrs Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>General</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>
13. FATHER'S NAME: <u>Harry Chenowith</u>		14. MOTHER'S MAIDEN NAME: <u>Rosanna Haas Schneider</u>		
15. WAR DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-2846</u>	17. INFORMANT & ADDRESS. <u>Mrs. Martha Hart, 3706 Woodlawn Ave. Baltimore</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSE (B) DUE TO <u>arteriosclerotic cardiovascular disease with hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>15 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1941</u> , to <u>23 Dec., 1955</u> , that I last saw the deceased alive on <u>23 Dec., 1955</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>J. Brown</u> ADDRESS <u>M.D. of Sykesville P.O., Maryland</u> DATE SIGNED <u>23 Dec. 1955</u>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12-27-1955</u>	NAME OF CEMETERY OR Crematory <u>Parkwood</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 24 1955</u>	REGISTRAR'S SIGNATURE <u>Robert R. Hemmings</u>	24. FUNERAL DIRECTOR ADDRESS <u>Ulrich & Son, Home Belts. Md.</u>		

BUREAU V. S.

DEC 28 1955

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11787

CERTIFICATE OF DEATH

11780

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CARROLL CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN Rural - Sykesville		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster STREET ADDRESS (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				
3. NAME OF DECEASED (First) IDA (Middle) BELLE (Last) DEAL (Type or Print)		4. DATE OF DEATH 12 14 19 55		
5. SEX <input checked="" type="checkbox"/> Female	6. COLOR OR RACE <input checked="" type="checkbox"/> White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/> Widowed	8. DATE OF BIRTH 4/9/82	9. AGE last birthday 73 yrs. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/> USA
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input type="checkbox"/> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Record, Springfield State Hospital	
18. MEDICAL CERTIFICATION				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Thrombophlebitis, right leg		INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
IMMEDIATE CAUSE (A) Thrombophlebitis, right leg		ANTECEDENT CAUSE(S) DUE TO Chronic brain syndrome associated with senile		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B)		brain disease, with psychotic reaction		
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with senile brain disease, with psychotic reaction				
4 years				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) Sykesville, Maryland (State)	
21d. TIME OF INJURY (Month) 12 (Day) 1 (Year) 19 55 (Hour) 4:00 A.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/1 19 55 to 12/11 19 55 , that I last saw the deceased alive on 12/13 19 55 , and that death occurred at 4:00 A.M. from the causes and on the date stated above. SIGNATURE Walker J. Sonnenfeld M.D. ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/14/55				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried + stored		DATE THEREOF 12/15/55	NAME OF CEMETERY OR CREMATORIAL Chas. of Med. - Med. School	LOCATION (City, town, or county) Baltimore, Md. (State)
24. REC'D BY REGISTRAR DATE 12/14/55		REGISTRAR'S SIGNATURE C. Harry Tracy	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

V.S. AISC 1-5 10M

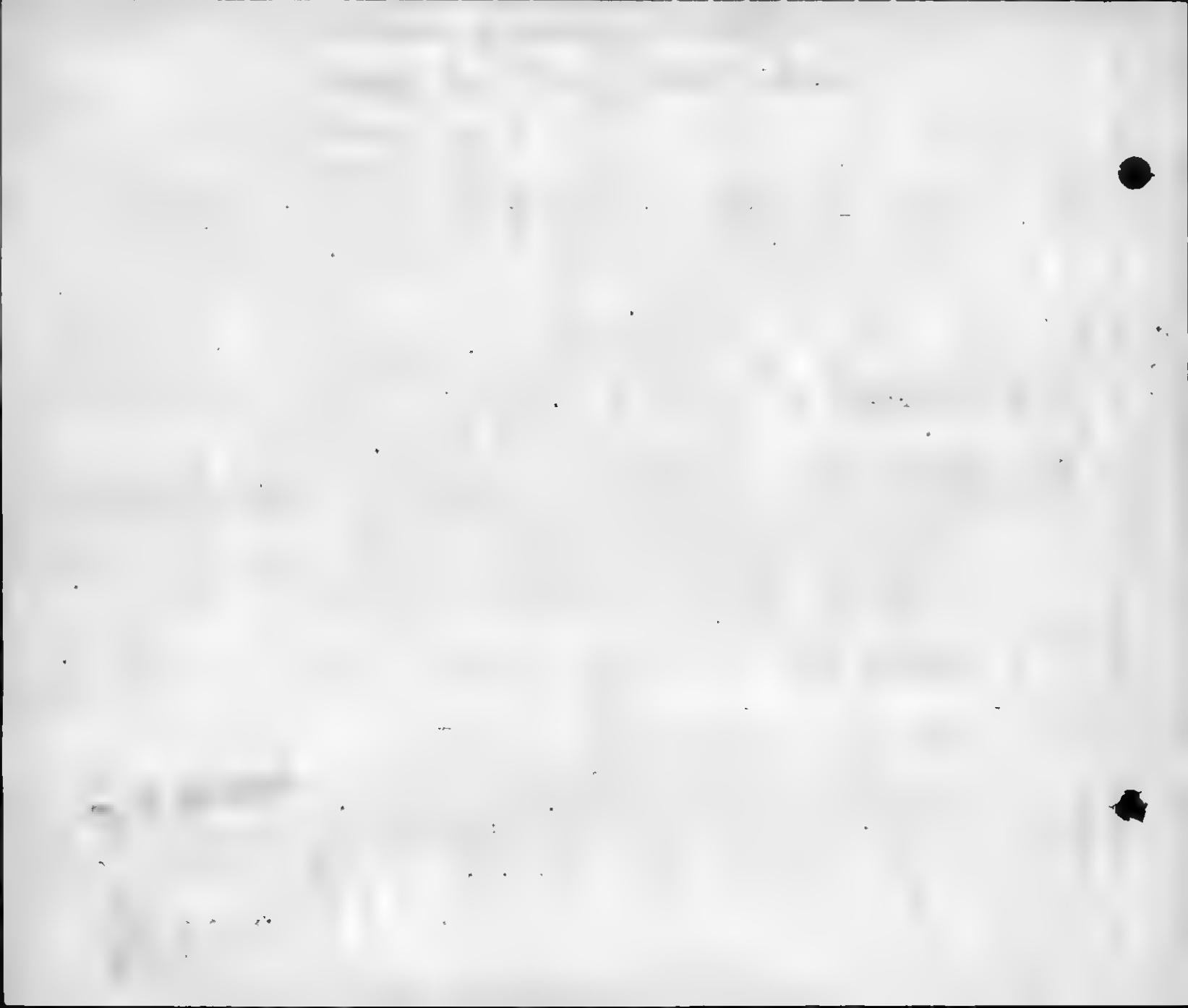
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11781

11788 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COLONY	Carroll	MARYLAND	Maryland COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <input checked="" type="checkbox"/> Rural - Sykesville	since 11-16-23		OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hospital		STREET ADDRESS 409 N. Carrollton Avenue (If rural give location)
3. NAME OF DECEASED (First) Victor W. DIXON		4. DATE OF DEATH December 6 1955	
(Type or Print)		(Middle)	(Day) (Year)
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH January 2, 1882
9. AGE last birthday 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Bottle Cap Mfg.	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? United States	13. FATHER'S NAME James Dixon	14. MOTHER'S MAIDEN NAME Bettie K. Smith	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no
16. SOCIAL SECURITY NO. unknown	17. INFORMANT & ADDRESS Records of Springfield State Hospital	18. MEDICAL CERTIFICATION	19. DATE OF OPERATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) Coronary occlusion	
ANTECEDENT CAUSE(S) DUE TO		Chronic myocarditis and myocardial degeneration	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST, DUE TO			
(B) (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Schizophrenic reaction, hebephrenic type	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, shop, etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 1st, 1947, to Dec. 5, 1955, that I last saw the deceased alive on Dec. 5, 1955, and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
ADDRESS (Street, city, town, state) DATE SIGNED			
Martin Gross, M.D. Sykesville, Maryland 12/6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/9/55	NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.
LOCATION (City, town, or county) Baltw., Md.		(State)	
24. REC'D BY REGISTRAR H. E. G. 1955		REGISTRAR'S SIGNATURE C. Harry Geers	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
		Kam. J. Vistner & Sons - Baltw. Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11782

11789 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

COUNTY Carroll MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN Sykesville, Maryland 5 yrs, 2 mos.

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Westernport, Maryland
 STREET ADDRESS (If rural give location)

R.F.D. # 1

3. NAME OF DECEASED: (First) (Middle) (Last)

(Type or Print)

Lula

Frances

Duckworth

4. DATE (Month) (Day) (Year)
OF DEATH. 12 28 19555. SEX: 6. COLOR OR 7. SINGLE, MARRIED,
RACE: WIDOWED, DIVORCED.
(Specify): Widowed

Female

White

DATE OF BIRTH: 10-25-1891

AGE last birthday

64

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Owen Derflinger

14. MOTHER'S MAIDEN NAME:

Yuk -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

Yuk -

17. INFORMANT & ADDRESS:

Hospital records

18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN
ONSET AND DEATH

IMMEDIATE CAUSE

(A)

Coronary occlusion

30 min.

ANTECEDENT CAUSE (B)

DUE TO

Alzheimer's Disease

7 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-28-1955, to 12-28-1959, that I last saw the deceased alive on 12-28-1955, and that death occurred at 10:40M, from the causes and on the date stated above.
 SIGNATURE Ilse Kamm, M.D. ADDRESS Sykesville, Md. DATE SIGNED 12-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Date, 29, 1955

C. Harry Wilson

D. P. Boal. Westernport, Md.

69 (1967)

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120000

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician or completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs AISC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11783

11790 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)		MARYLAND		STATE CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY TOWN Baltimore City	
X Carroll Sykesville		Length of Stay (In this place) 216 years +		Maryland Baltimore		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Springfield State Hospital				STREET ADDRESS			
3. NAME OF DECEASED (First) Herman Eckmeyer (Middle)				4. DATE (Month) OF DEATH 12 (Day) 21 (Year) 1955			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) unknown	8. DATE OF BIRTH unknown	9. AGE last birthday 64 yrs.	IF UNDER 1 YR. Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? not known	
13. FATHER'S NAME not known				14. MOTHER'S MAIDEN NAME not known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk.				16. SOCIAL SECURITY NO. not known		17. INFORMANT & ADDRESS Hospital records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 715 X IMMEDIATE CAUSE (A) Septicemia				INTERVAL BETWEEN ONSET AND DEATH weeks			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO 905-7 (C)				Decubitus ulcer weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture of neck of left femur 26 years + 3 hrs +							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Rockville			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1-19-55		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Knocked by a disturbed patient.			
22. I hereby certify that I attended the deceased from July 19, 1955, to Oct. 12, 1955, that I last saw the deceased alive on Oct. 12, 1955, and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
SIGNATURE Walter H. Sonnenfeld ADDRESS (Street, city, town, state) Springfield State Hospital DATE SIGNED 12/3/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/6/55		NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery		LOCATION (City, town, or county) Germantown	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE C. Harry Steers		25. FUNERAL DIRECTOR'S SIGNATURE J. J. Tobey		ADDRESS	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11784

11769

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY 27 Carroll	MARYLAND	STATE Maryland	COUNTY Carroll		
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Westminster		LENGTH OF STAY (In this place) 12 years	CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN Westminster		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 27 54½ Carroll Street		STREET ADDRESS (If rural give location) 54½ Carroll Street			
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
Florence Sarah Fitz			Dec. 1 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 12, 1873	9. AGE less birthday 82 yrs.	IF UNDER 1 YEAR Months Deyrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Carroll County, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME T. John E. Hesson			14. MOTHER'S MAIDEN NAME Mary Harner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS Rachel Fitz Westminster, Md.	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <i>acute cerebral hemorrhage</i> 24 hours ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>General arterioclerosis</i> 10 yrs GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/30 1955</i> to <i>12/1 1955</i> , that I last saw the deceased alive on <i>12/1 1955</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Blithen Barr M.D.</i> ADDRESS (Street, city, town, state) <i>Westminster Md.</i> DATE SIGNED <i>12/2/55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec. 3, 1955	NAME OF CEMETERY OR CREMATORIUM Baust Cemetery	LOCATION (City, town, or county) Tyrone, Maryland (State)		
24. REC'D BY REGISTRAR DATE <i>12-3-55</i>	REGISTRAR'S SIGNATURE <i>Harold Miller</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John R. Byers Westminster, Md.			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11791

CERTIFICATE OF DEATH

Reg. Dist. No. 83

11785

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>HANOVER</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Woodbine</u>		LENGTH OF STAY (in this place) <u>4 years</u>	
3. NAME OF DECEASED: (First) (Type or Print) <u>SARAH A. FLOHR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec 16 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH: <u>5/19/1876</u> 9. AGE last birthday <u>79</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Massey</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war & dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>John B. Flohr, 15 Maryland Ave, Catonsville MD</u>			
18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 years.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 1955, to <u>Dec., 1955</u> , that I last saw the deceased alive on <u>December 5, 1955</u> , and that death occurred at <u>2:05 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>W.B. Culwell</u> ADDRESS <u>Dent. Airy Md.</u> DATE SIGNED <u>12/16/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/19/55</u> NAME OF CEMETERY OR CREMATORIUM <u>Springfield</u> LOCATION (City, town, or county) (State) <u>Carroll Co Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1955</u>		REGISTRAR'S SIGNATURE <u>Edna Hewitt B.</u> 24. FUNERAL DIRECTOR <u>Joe Dabb & Son</u> ADDRESS <u>28</u>	

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PICTURE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC L-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11792 CERTIFICATE OF DEATH

11786

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN Rural - Sykesville HOSPITAL OR INSTITUTION OR STREET ADDRESS <input checked="" type="checkbox"/> Springfield State Hospital	MARYLAND LENGTH OF STAY (in this place) 4Y, 4M, 21 days	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville STREET ADDRESS 15 - 26 - 2	COUNTY Montgomery (If rural give location)
3. NAME OF DECEASED (Type or Print) ROSA ALICE CROSHON		4. DATE (Month) (Day) (Year) OF DEATH 12 12 55	
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 6/8/79
9. AGE last birthday yrs. 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Frederick County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Louis Craver		
14. MOTHER'S MAIDEN NAME Laura Ramsburg		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/>	
16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Record, Springfield State Hospital	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) Arteriosclerotic heart disease			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Generalized arteriosclerosis			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Chronic brain syndrome associated with senile brain disease, senile Parkinsonism			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH years	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 10/4 1955 12:00 P.M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/4, 1955, to 12/12, 1955, that I last saw the deceased alive on 12/11, 1955, and that death occurred at 9:20 A.M., from the causes and on the date stated above.			
ADDRESS (Street, city, town, state) Sykesville, Maryland 12/12/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF NAME OF CEMETERY OR CREMATORIUM DEC. 14.1955 LAYTONSVILLE, CEMT LAYTONSVILLE MD	
24. REC'D BY REGISTRAR DATE DEC. 15, 1955		REGISTRAR'S SIGNATURE C. Harry Wren	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Roy W. Barber, Laytonsville Md			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11787

11793 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY	Carroll			STATE	Maryland Baltimore		
CITY (If outside corporate limits, write RURAL or and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN	Rural- Sykesville			LENGTH OF STAY (In this place)	Baltimore		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hospital			STREET ADDRESS	(If rural give location)		
15				3700 East Pratt Street			
3. NAME OF DECEASED (First) Margaret (Middle) Martha (Last) GROSS				4. DATE (Month) (Day) (Year) OF DEATH 12 5 1955			
5. SEX Female		6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 8/1/93	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Monhs	IF UNDER 24 HRS. Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Robert Gross				14. MOTHER'S MAIDEN NAME Belle Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Record, Springfield State Hospital			
18. MEDICAL CERTIFICATION							
IMMEDIATE CAUSE (A) Cerebral hemorrhage 24 hours							
ANTECEDENT CAUSE(S) DUE TO cerebral arteriosclerosis years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Generalized arteriosclerosis years							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Epilepsy with mental deficiency years							
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/4/1955 to 12/5/1955 that I last saw the deceased alive on 12/4/1955, and that death occurred at 1:15A.M. from the causes and on the date stated above.							
SIGNATURE <i>Martha J. Sommersell</i> ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/5/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 8/1955	NAME OF CEMETERY OR CREMATORIAL Caskets		LOCATION (City, town, or county) Eastern Boro.		
24. REC'D BY REGISTRAR DEC.		REGISTRAR'S SIGNATURE C. Harry Marx	25. FUNERAL DIRECTOR'S SIGNATURE J. J. Connally Essey		ADDRESS		

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for us as a burial transit permit.

VS AISC 1-5-10M
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11788

11794 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If rural give location)	
TOWN Sykesville		9 mos.		TOWN Cumberland		01	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital				STREET ADDRESS 801 Bedford Street			
3. NAME OF DECEASED (Type or Print) SHANON AMBROSIE HARDMAN				4. DATE (Month) (Day) (Year) DEATH Dec. 11 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4-8-64	9. AGE last birthday 91 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Agent			10b. KIND OF BUSINESS OR INDUSTRY unk -			11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Levi Hardman				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) unk.				16. SOCIAL SECURITY NO. unk			
17. INFORMANT & ADDRESS Hospital records							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
44.5 IMMEDIATE CAUSE (A) Terminal pneumonia ANTECEDENT CAUSE(S) DUE TO unk DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) unk STATING UNDERLYING CAUSE LAST. DUE TO unk (C) Hypertensive heart disease years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile psychosis, simple deterioration.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work		21f. HOW DID INJURY OCCUR? Not while at work		(State)	
22. I hereby certify that I attended the deceased from 4-28 1955 to 12-11 1955, that I last saw the deceased alive on 12-11 1955, and that death occurred at 7 P.M. from the causes and on the date stated above.							
SIGNATURE <i>A. Lubitska</i>							
M.D. Springfield State Hosp. Sykesville 12-11-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-14-55		NAME OF CEMETERY OR CEMMORTORY St. Peter's		LOCATION (City, Town, or county) Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 12-12-55		Dr. Harry Ween		Louis J. Attia Jr. Cumberland, Md.			

DUANEAU V. S.

DEC 15 1955

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11789

11795 CERTIFICATE OF DEATH

Reg. Dist. No. 76

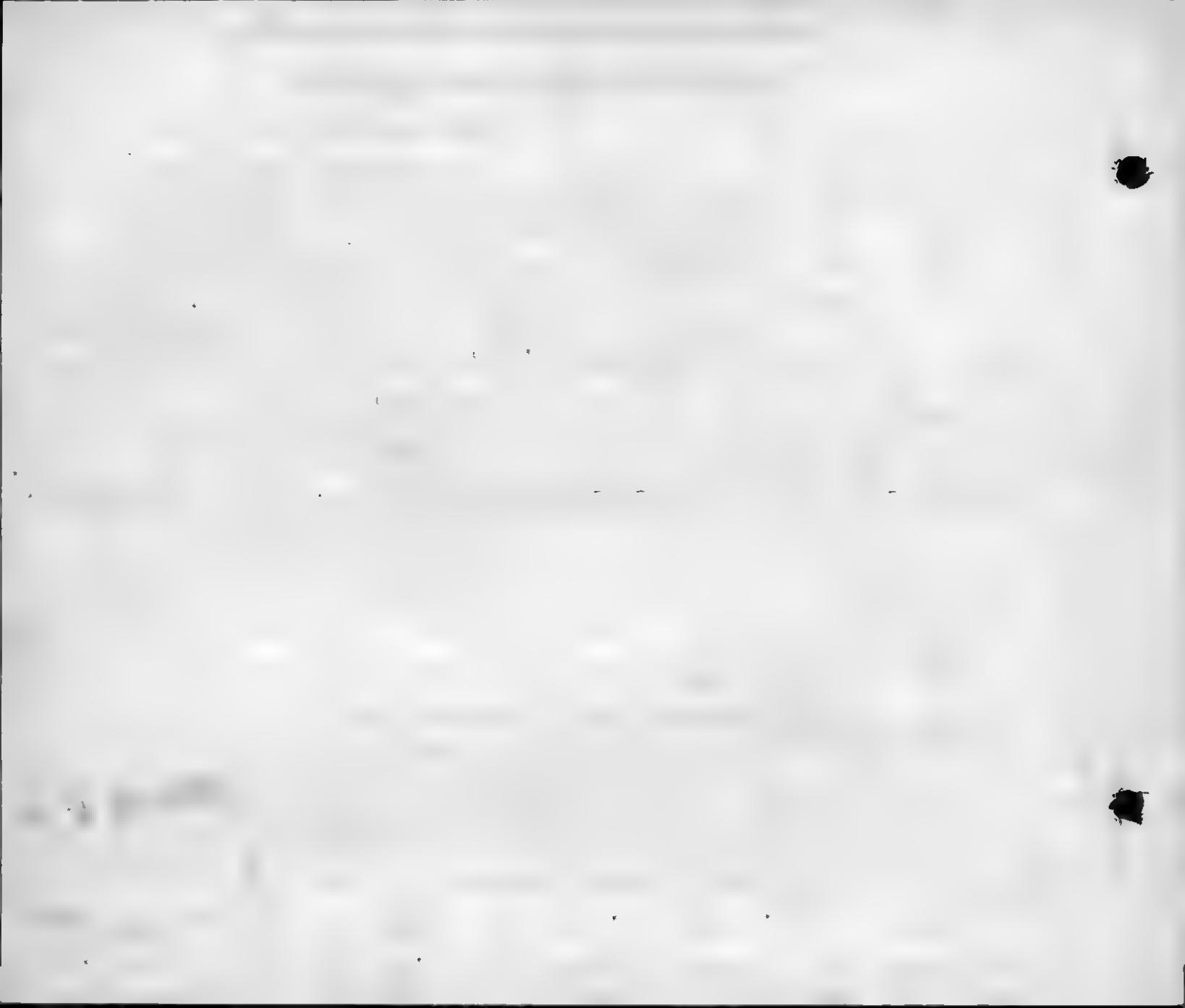
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Carroll rural Westminster	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL and give nearest town) TOWN rural Westminster
HOSPITAL OR INSTITUTION OR STREET ADDRESS	19 Locust Street	STREET ADDRESS (If rural give location)	19 Locust Street
3. NAME OF DECEDENT (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) Augustus (Middle) George (Last) Humbert		DEATH Dec. 4 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 24, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE last birthday 86 yrs. IF UNDER 1 YEAR Months Days Hours Min.
13. FATHER'S NAME George Humbert		14. MOTHER'S MAIDEN NAME Sarah Gunder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO. 219-12-0084	17. INFORMANT & ADDRESS Clarence A. Humbert Westminster, Md.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>33 IX IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i></p> <p>ANTECEDENT CAUSE(S) DUE TO <i>arteriosclerosis</i></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (B) (C)</p>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1 1955 to Dec 4 1955 that I last saw the deceased alive on Dec 3 1955, and that death occurred about 10 A.M. from the causes and on the date stated above.			
SIGNATURE <i>Weese Wilkins</i> M.D. ADDRESS (Street, city, town, state) <i>15 Remer ave Westminster MD</i> DATE SIGNED <i>8/5/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec. 6, 1955	NAME OF CEMETERY OR Crematory St. Mary's Cemetery	LOCATION (City, town, or county) (State) Silver Run, Maryland
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>James J. Miller</i>	25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Md.	
DATE <i>11-6-55</i>	ADDRESS		



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10.W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

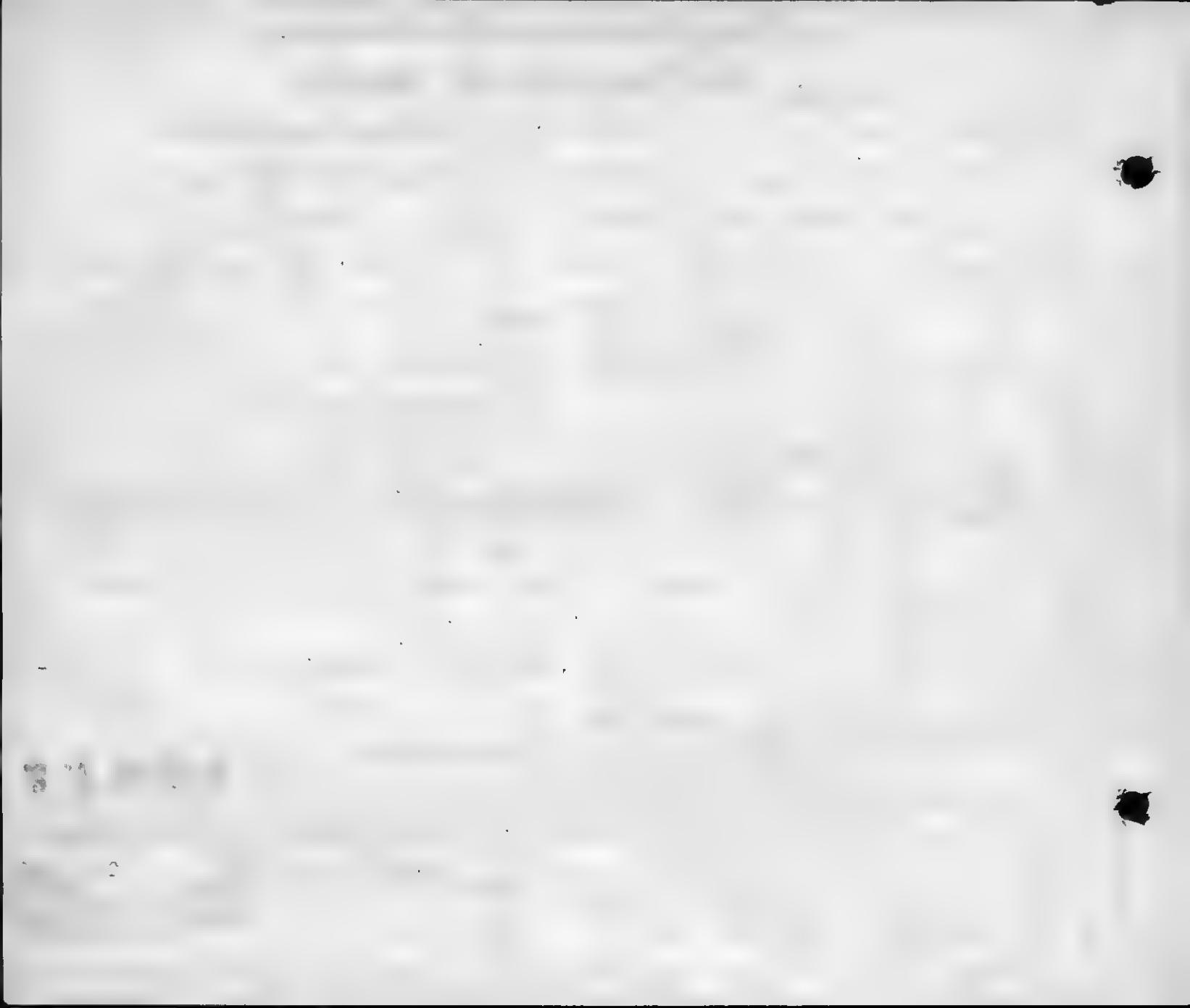
11790

11796

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X Rural - Sykesville		4 months		TOWN Baltimore		S. V 21-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS 920 N. Castle Street		(If rural give location)			
3. NAME OF DECEDENT (Type or Print) FRANCES DALESICKY JECELIN				4. DATE OF DEATH 12 4 19 55			
S. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	B. DATE OF BIRTH 10/14/75	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia (Bohemia)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Record, Springfield State Hospital			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Cerebral hemorrhage							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Hypertensive cardiovascular disease							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Generalized arteriosclerosis							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH 2 days			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/21, 19 55, to 12/4, 19 55, that I last saw the deceased alive on 12/1, 19 55, and that death occurred at 8:20 P.M. from the causes and on the date stated above.							
SIGNATURE Walter H. Sonnenfeldt M.D.							
ADDRESS (Street, city, town, state) Sykesville, Maryland							
DATE SIGNED 12/25/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12-8-1955		NAME OF CEMETERY OR CREMATORIAL OAK HILL		LOCATION (City, town, or county) BALTIMORE MD	
24. REC'D BY REGISTRAR P.B. 1955		REGISTRAR'S SIGNATURE P.B. 1955		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FR. CAVACH & SON 900 N. CHESTER ST.			
DATE							



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC-155 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11791

11797 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Baltimore City (If rural give location)	
X Carroll Sykesville				/ Springfield State Hosp			
3. NAME OF DECEASED (First) ROZELLA (Middle) E. (Last) JOHNS				4. DATE OF DEATH (Month) 12 (Day) 25 (Year) 55			
5. SEX Fe	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6-30-1875	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months 5 Days 25 Hours — Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sch. teacher			10b. KIND OF BUSINESS OR INDUSTRY School	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard H. Johns			14. MOTHER'S MAIDEN NAME Eurith E. Leach				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unk.] NO		16. SOCIAL SECURITY NO. Yuk		17. INFORMANT & ADDRESS Millie Register (sister) 6823 Thomas Blvd. Pittsburgh, PA.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Acute mesenteric Thromboasis IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Schizophrenia - Paranoid type.					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-9 1936, to 12-25 1955, that I last saw the deceased alive on 12-25 1955, and that death occurred at 6:05 A.M. from the causes and on the date stated above.							
SIGNATURE <i>June R. Hoffmann</i> ADDRESS (Street, city, town, state) <i>Springfield State Hosp.</i> DATE SIGNED <i>12-25-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-27-55		NAME OF CEMETERY OR CREMATORY Greenwood		LOCATION (City, town, or county) (State) Baltimore, Md.	
24. REC'D BY REGISTRAR DATE 12-25-55		REGISTRAR'S SIGNATURE <i>C. Harry Weller</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Alfredo Morris Co., 10820 Heath Ave</i>			

BURLAY V. S.

DEC 23 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **4 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

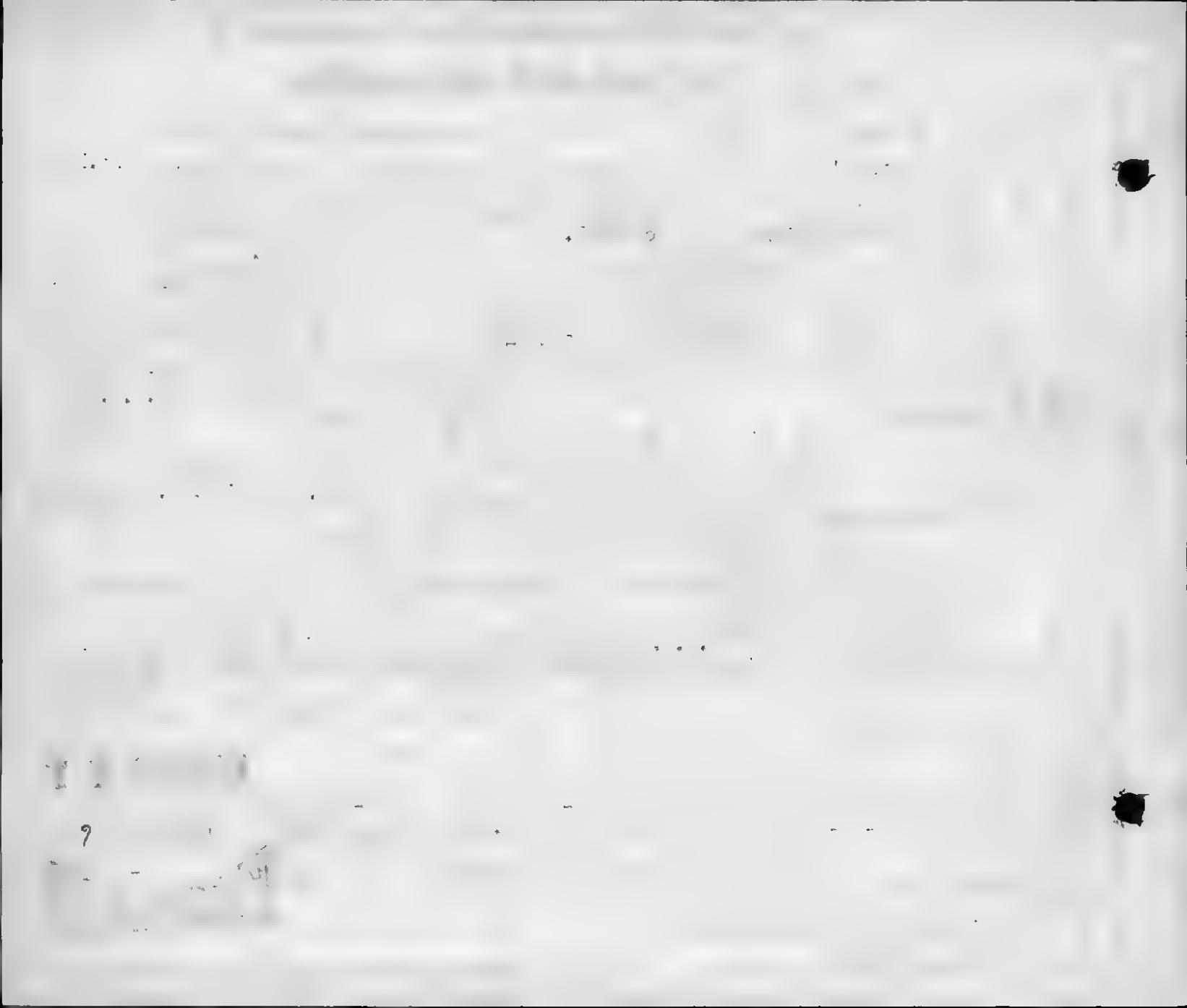
VS AISC 1-55 10W

11798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	COUNTY Frederick Co. 121 (If rural give location)
X HOSPITAL OR INSTITUTION OR STREET ADDRESS Sykesville Springfield State Hospital.		7 months 25 days STREET ADDRESS 36 Franklin St.	
3. NAME OF DECEASED (First) Bessie (Middle) Elizabeth (Last) Kemp		4. DATE OF DEATH 12 30 1955 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 10-23-1893
9. AGE last birthday 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Peddieord		14. MOTHER'S MAIDEN NAME Mary Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. unk		17. INFORMANT & ADDRESS Mrs Eleanor Sheckles 36 Franklin St. Frederick, Md. (daughter)
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Hypertensive cardio-vascular disease ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. other than cerebral arteriosclerosis with psychotic reaction two years			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5-5, 1955, to 12-30, 1955, that I last saw the deceased alive on 12-30, 1955, and that death occurred at 2.15a.M. from the causes and on the date stated above. SIGNATURE Walter H Sonnenfeldt M.D. Springfield State Hospital DATE SIGNED 12-30-1955 ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 1/2/56	NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery
24. REC'D BY REGISTRAR		LOCATION (City, town, or county) Frederick Md	
DATE DEC. 31, 1955		REGISTRAR'S SIGNATURE C. Harry Wheeler	
25. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick Md	



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial tract permit.

VS A15C-155 10/M

11770

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Baltimore City (If rural give location)	
27 Carroll HOSPITAL OR INSTITUTION OR STREET ADDRESS		3 months 48 Longwell Ave.		Maryland Baltimore City 1216 N. Calvert St.			
3. NAME OF DECEASED (First) SALLIE (Middle) ELIZABETH (Last) LANE				4. DATE OF DEATH Dec. 10 1955			
5. SEX f.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Aug. 15, 1877	9. AGE last birthday 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) of Leonard Labatt, Md. U.S.A.			
13. FATHER'S NAME Alexander J. Bowen				14. MOTHER'S MAIDEN NAME Betty Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS Mrs. Clara D. Schaffer, Westmin				18. MEDICAL CERTIFICATION myocardial degeneration 2 yrs			
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
20. INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
21a. DATE OF OPERATION				21b. MAJOR FINDINGS OF OPERATION			
21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21d. PLACE (Home, farm, factory, street, office bldg., etc.)			
21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21f. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21g. HOW DID INJURY OCCUR?				21h. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Aug. 15, 1955, to Dec. 10, 1955, that I last saw the deceased alive on Dec. 9, 1955, and that death occurred at 11 AM, from the causes and on the date stated above. SIGNATURE C. Reese Wilkins M.D. ADDRESS (Street, city, town, state) Westminister 1090 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 19, 1955	NAME OF CEMETERY OR CREMATORIUM Beldam Memorial Cemetery, Bellsville, Md.		LOCATION (City, town, or county) (State)		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harriet Jones	25. FUNERAL DIRECTOR'S SIGNATURE Warren Cook Funeral Service Baltimore		ADDRESS		
DATE 12-11-15							

A small, stylized illustration of a person in traditional East Asian clothing, possibly a scholar or a figure from a story, standing and facing right.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11794

11799

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Carroll Manchester	15 yrs	Md Manchester	Carroll
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) ANNA - MAE - LEISTER		OF DEATH Dec 30 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Fr	W	Maid Jan 21 1930	9. AGE last birthday 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
NUR		our home	Md
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles Koerner		Sadie M. Shaffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		415-26-8878 Harold A Lester-Manchester Md	
18. MEDICAL CERTIFICATION		17. INFORMANT & ADDRESS	
IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		Pulmonary Tuberculosis Pulmonary Hemorrhage	
		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		5 minutes	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from September 19, 50, to December 19, 55, and last saw the deceased alive on 12-25, 1955, and that death occurred at 1:30 P.M., from the causes and on the date stated above. SIGNATURE W. H. Foward ADDRESS (Street, city, town, state) Manchester, Md. DATE SIGNED 12-30-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan 2-55 NAME OF CEMETERY OR CREMATORIUM Suydenburg LOCATION (City, town, or county) Carroll Co Md (State)	
24. REC'D BY REGISTRAR Mrs. H. H. Danner		REGISTRAR'S SIGNATURE	
DATE Dec 31-55		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edw A Tipton-Hampton Md	

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JAN
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11800

CERTIFICATE OF DEATH

11795

Reg. Dist. No.

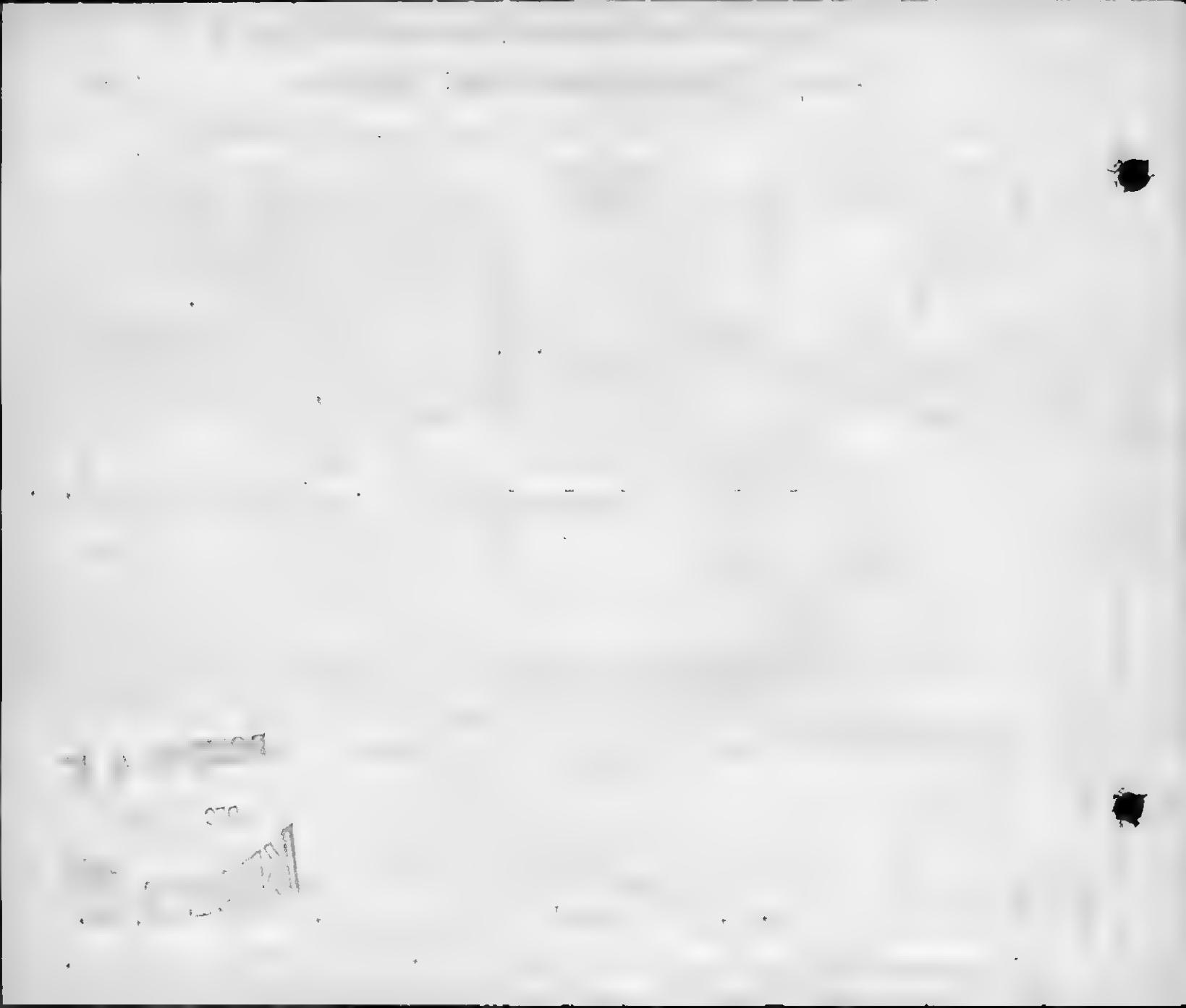
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C-55 10W

1. PLACE OF DEATH CITY Carroll MARYLAND TOWN rural Westminster LENGTH OF STAY (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS R 4 Gorsuch Road		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN rural Westminster STREET ADDRESS (if rural give location) R 4 Gorsuch Road	
3. NAME OF DECEASED (Type or Print) Elizabeth Keziah Lester		4. DATE (Month) (Day) (Year) OF DEATH Dec. 15 1955	
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 18, 1885
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Aaron Shaffer		14. MOTHER'S MAIDEN NAME Mary Bankert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT & ADDRESS Howard J. Leister Westminster, Md.		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Generalized arterio sclerosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY straat, officia bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. M.		21f. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from..... alive on 12-15-55, and that death occurred at 347 P.M., from the causes and on the date stated above. SIGNATURE James J. Moose M.D. ADDRESS (Street, city, town, state) Westminster Md. DATE SIGNED 12/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 19, 1955 NAME OF CEMETERY OR CREMATORIUM Krider's Cemetery LOCATION (City, town, or county) nr. Westminster, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE John R. Byers ADDRESS	
DATE 12-18-55		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.	



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10.1K

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11801

CERTIFICATE OF DEATH

11796

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY <u>Carroll</u> CITY (if outside corporate limits, write RURAL OR end give nearest town) <input checked="" type="checkbox"/> TOWN <u>Sykesville, Maryland</u>		MARYLAND LENGTH OF STAY (In this place) <u>1 yr. 8 mo. 21 days</u>		STATE <u>Maryland</u> CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		COUNTY <u>Orester</u> (If rural give location) <u>6113-2</u>		
<input checked="" type="checkbox"/> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS <u>301 Peach Blossom Street</u>				
3. NAME OF DECEASED (Type or Print) <u>THELMA</u>				4. DATE OF DEATH <u>12 12 1955</u>				
5. SEX <input checked="" type="checkbox"/> Female	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5-20-13</u>	9. AGE last birthday <u>12 yrs.</u>	IF UNDER 1 YEAR Months <input checked="" type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frank Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Murphy</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> If Yes, give war or dates of service) <u>o</u>		16. SOCIAL SECURITY NO. <u>50-1234567</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>				
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>								
ANTECEDENT CAUSE(S) DUE TO <u>Heart Fibrillation</u>								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO <u>Pulmonary Tuberculosis</u>								
C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with convulsive disorder, psychotic reaction.</u>								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>Sykesville, Maryland</u> (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work						
21f. HOW DID INJURY OCCUR?								
22. I hereby certify that I attended the deceased from <u>3-16</u> , 19 <u>55</u> , to <u>12-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.								
SIGNATURE <u>Walter St. Johnenfeldt</u> M.D. ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u> DATE SIGNED <u>12-12-55</u>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Casket</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORIUM <u>Vizanno Cemetery</u>		LOCATION (City, town, or county) <u>Kensington, Maryland</u> (State) <u>Md.</u>		
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Lee</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward H. Hubbard</u>		ADDRESS <u>4107 Wilkins Ave</u>		
DATE <u>Dec 26, 1955</u>								

S.A.C.

100

DEPARTMENT OF JUSTICE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11797

CERTIFICATE OF DEATH

Iter 8, Film #90 12-27-55 et

Reg. Dist. No. 26

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND COUNTY Carroll Rural, Westminister
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Westminster 7yr	STREET ADDRESS	Liberty St. aptd.
3. NAME OF DECEASED (Type or Print)	4. DATE OF DEATH DEC. 14 1955		
SARAH JANE MANGER	(First)	(Middle)	(Last)
5. SEX F.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 1875 March 24, 1874 80
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Carroll Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ephraim Mayer Brown	14. MOTHER'S MAIDEN NAME Elizabeth Myers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	INTERVAL BETWEEN ONSET AND DEATH 2 yrs
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE Arteriosclerotic heart disease ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis 8 yrs			
III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) Westminster	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1955 to Dec. 14, 1955, that I last saw the deceased alive on Dec. 13, 1955, and that death occurred at 12:45 AM, from the causes and on the date stated above. SIGNATURE Crescent Mangers M.D.			
23. BURIAL/CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Dec. 16-55	NAME OF CEMETERY OR CREMATORIUM Crescent Cemetery	LOCATION (City, town, or county) Westminster
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Hamlet Rubin	25. FUNERAL DIRECTOR'S SIGNATURE J. S. Manger, Jr., Westminster, Md.	ADDRESS
DATE 12-15-1955			



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11798

CERTIFICATE OF DEATH

11803

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Carroll Rural	MARYLAND LENGTH OF STAY (In this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hosp.		STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)	(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH 12 23 19 55
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH ? ? 18 74
9. AGE last birthday 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk	10b. KIND OF BUSINESS OR INDUSTRY Yach	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME John Donhue	14. MOTHER'S MAIDEN NAME Hanora Donhue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unknown	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT & ADDRESS Records of Springfield Hospital	18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Cerebro-Vascular Accident ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Hypertensive DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 20 Minutes
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	15 Yrs.
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 6, 19 52, to Dec. 23, 19 55, that I last saw the deceased alive on Dec. 23, 19 55, and that death occurred at 11 P.M., from the causes and on the date stated above. SIGNATURE <i>Sylvanus Radley Reynolds</i> ADDRESS (Street, city, town, state) <i>55th</i> DATE SIGNED <i>12-24-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF 12-24-55	NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral</i>	LOCATION (City, town, or county) <i>Bald 7nd.</i> (State)
24. REC'D BY REGISTRAR DATE 12 24 55	REGISTRAR'S SIGNATURE <i>C. Harry Mearns</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Mearns</i>	ADDRESS <i>108-805 N. Calvert St.</i>

BALTIMORE V.

DEC 10 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11799

11804

CERTIFICATE OF DEATH

Reg. Dist. No. 74

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY TOWN Baltimore (If rural give location)	
X TOWN Sykesville		24 years		STREET ADDRESS 2821 Chesterfield Avenue			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital							
3. NAME OF DECEASED (First) Anna Marie Meisel (Type or Print)				4. DATE OF DEATH Dec. 9 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married W	8. DATE OF BIRTH 9-18-1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigarette maker				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Frank Schoenholtz				14. MOTHER'S MAIDEN NAME Caroline Fleishman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY NO. Huck			
17. INFORMANT & ADDRESS Hospital records							
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
025 X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Minutes General Paresis			
(A) Cerebral Vascular Accident				Years			
(B) General Paresis							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Psychosis with Cerebro-spinal syphilis			
19a. DATE OF OPERATION 12				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-25, 1931, to 12-9, 1955, that I last saw the deceased alive on 12-9, 1955, and that death occurred at 9:40A.M. from the causes and on the date stated above.							
SIGNATURE Gerhard Sykesville M.D., Springfield State Hospital, Sykesville Md.							
ADDRESS (Street, city, town, state) DATE SIGNED 12/9/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 12, 1955		NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery		LOCATION (City, town, or county) Baltimore, Maryland	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck, 5305 Harford Road #14							
DATE DEC. 10, 1955 C. Harry Tidwell							

HUNZEAU M. G.

DEC 15 1955

SELLVILLE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W
11805

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11800

11805

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Prince George <i>11/16/55</i>	
Carroll Sykesville		33 yr. 6 mo. 25 days		Mt. Rainier <i>3210 Upper St</i>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Springfield State Hospital</i>		STREET ADDRESS					
3. NAME OF DECEASED (First) <i>AMANDA</i> (Middle) <i></i> (Last) <i>MILLER</i>				DATE OF DEATH <i>12 19 1955</i>			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH March 27, 1885	
9. AGE last birthday 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Typist</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James W. Miller		14. MOTHER'S MAIDEN NAME Sally Blair		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Hospital records</i>		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.0 IMMEDIATE CAUSE (A) Acute edema of lung ANTECEDENT CAUSE(S) DUE TO (B) Myocardial Infarction DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>hrs. hrs. yrs.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Dementia Praecox - hebephrenic type.</i>				33 yr. +			
19a. DATE OF OPERATION <i>12/22/55</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>(County) (State)</i>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M. at work</i>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>12-19 1955</i> to <i>12-19 1955</i> , that I last saw the deceased alive on <i>12-19 1955</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Walter J. Sonnenfeld</i> M.D. <i>Sykesville, Maryland</i> DATE SIGNED <i>12-20-55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/22/55</i>		NAME OF CEMETERY OR CREMATORIUM <i>Parks Knights Cam Co</i>		LOCATION (City, town, or county) <i>Brunswick, Md.</i>	
24. REC'D BY REGISTRAR <i>DEC 22 1955</i>		REGISTRAR'S SIGNATURE <i>Victor E. Davis</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>F. Giesela Sonnenthal</i>		ADDRESS <i>Waverly, Md.</i>	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be submitted for us as a burial transit permit.

VS AISC 1-S5 10A
DATE - 12/29/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11801

11806

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rural - Sykesville		7 days		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Springfield State Hospital		STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)		(First) SAMUEL	(Middle) HULETT	(Last) PENNINGTON	4. DATE OF DEATH (Month) 12 (Day) 27 (Year) 1955		
5. SEX <input checked="" type="checkbox"/>	6. COLOR OR RACE Male white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10/15/96	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY automobile		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lee R. Pennington				14. MOTHER'S MAIDEN NAME Lareine M. Hulett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 536-10-3883		17. INFORMANT & ADDRESS Record, Springfield State Hospital			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Irreversible Shock							
ANTECEDENT CAUSE(S) DUE TO perforated gastric ulcer							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (B) Chronic brain syndrome with psychotic reaction due to cerebral arteriosclerosis (C) 1 day							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 1 month							
19a. DATE OF OPERATION 12/26/55		19b. MAJOR FINDINGS OF OPERATION Perforated gastric ulcer and bile peritonitis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) 12/27/55 (Day) 1955 (Year) 1955 (Hour) 10:30 AM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/26/55 , 19 55 , to 12/27/55 , 19 55 , that I last saw the deceased alive on 12/27/55 , 19 55 , and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/27/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 12/29/1955		NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		LOCATION (City, town, or county) Baltimore, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE C. Harry Davis		25. FUNERAL DIRECTOR'S SIGNATURE Leviworth L. Armacost		ADDRESS Ellsworth Armacost - 4600 Liberty Heights, Ave.	

BESTIALITY

REVIEWED

DEC
11
1968

11807

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

COUNTY *Carroll*
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN *Winfield*

MARYLAND
 LENGTH OF STAY
(In this place)
Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Md.* COUNTY *Carroll*
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN *Winfield*
 STREET ADDRESS
 (If rural give location)

3. NAME OF

(First) *Edgar*(Middle) *E.*(Last) *Pickett*

(Type or Print)

4. DATE (Month) (Day) (Year)

5. SEX:

6. COLOR OR

7. SINGLE, MARRIED,

8. DATE OF BIRTH:

RACE:

WIDOWED, DIVORCED,

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired.)10B. KIND OF BUSINESS
OR INDUSTRY

9. AGE last birthday

73 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

13. FATHER'S NAME:

Tom W. Pickett

14. MOTHER'S MAIDEN NAME:

*Anna Haines*16. WAR DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

18. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

*FWD**None**Mr Bertha Pickett - Westmire Rd. 6.*18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH*154X*

IMMEDIATE CAUSE

(A) DUE TO

*Generalized carcinomatosis*INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSE (\$)

(B) DUE TO

adenocarcinoma of rectum

3+ Months

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

1+ years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

adenocarcinoma of rectum

20. AUTOPSY?

YES NO 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21E. INJURY OCCURRED
While at work Not while at work

21F. HOW DID INJURY OCCUR?

OF INJURY

M.

INJURY OCCURRED

22. I hereby certify that I attended the deceased from *1954*, 19..., to *14 Dec.*, 1955, that I last saw the deceased
alive on *12 Dec.*, 1955, and that death occurred at *6:30 AM*, from the causes and on the date stated above.
SIGNATURE *J. M. Farmer* ADDRESS *Dykesville, Md.* DATE SIGNED *14 Dec. 1955*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)DATE THEREOF *12-16-55*NAME OF CEMETERY OR CREMATORIUM *Ebenszer*LOCATION (City, town, or county) (State)
*Winfield, Carroll, Md.*DATE REC'D BY LOCAL
REGISTRAR *Dec. 15, 1955*REGISTRAR'S SIGNATURE *J. M. Farmer*

24. FUNERAL DIRECTOR

ADDRESS
Gated Knob - Sykesville, Md.

12-24-1955

BUREAU V.

DEC 28 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This requires that the death certificate be executed within 48 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A
The bottom copy may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11803

11808

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place) 3 yrs. 9 mos.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Baltimore City (If rural give location) 4114 Fernhill Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Springfield State Hospital		
3. NAME OF DECEASED (Type or Print)	(First) Emma	(Middle) Louise	(Last) Pindell
S. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-22-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) Ogdensburg, New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Farley	14. MOTHER'S MAIDEN NAME Fanny Houmier		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes	16. SOCIAL SECURITY NO. 788-12-1234	17. INFORMANT & ADDRESS Hospital Records	INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4. IMMEDIATE CAUSE Antecedent cause(s) DUE TO	Lobar pneumonia		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	Chronic myocarditis		
	Gen'l. arteriosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work	21f. WHERE DID INJURY OCCUR? (City or town) (County) (State)	21f. HOW DID INJURY OCCUR?
Not while at work			
22. I hereby certify that I attended the deceased from 6-27-1952, to 12-21-1955, that I last saw the deceased alive on 12-21-1955, and that death occurred at 7:30A.M. from the causes and on the date stated above.			
SIGNATURE <i>Winston M. N.</i>		ADDRESS (Street, city, town, state) DATE SIGNED M.D. Springfield State Hosp. Sykesville, 12-23-55	
23. BURIAL, Cremation, REMOVAL (SPECIFY) Burial	DATE THEREOF 17-27-55	NAME OF CEMETERY OR CREMATORIUM London Park	LOCATION (City, town, or county) (State) Baltimore Md
24. REC'D BY REGISTRAR DATE Dec. 24, 1955	REGISTRAR'S SIGNATURE C. J. Murphy, Clerk	25. FUNERAL DIRECTOR'S SIGNATURE W. C. Cook, Jr. 12-23-55	ADDRESS Burke H. Ball, Md.

BUREAU Y-8

DEC 23 1955

REGIME

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11804

11809

CERTIFICATE OF DEATH

Reg. Dist. No. 74

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (in this place) 3mos. 29days	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS	COUNTY Maryland Howard Pasadena, Route 5 -- Box 205
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital			
3. NAME OF (First) Evelyn (Middle) Ridgely (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH 12 14 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11-17-1877
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY <i>usep</i>	9. AGE last birthday 78 yrs.
13. FATHER'S NAME Humphrey Dorsey		11. BIRTHPLACE (State or foreign country) Pasadena, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
(If Yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>47-00000</i>		17. INFORMANT & ADDRESS Hospital records	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Coronary Thrombosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Generalized arteriosclerosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-12-1955, to 12-13-1955, that I last saw the deceased alive on 12-13-1955, and that death occurred at 11:00 AM, from the causes and on the date stated above. SIGNATURE M. N. Martin, M.D. <i>M. N. Martin M.D.</i> M.D. Springfield State Hosp., Sykesville 12-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF 12-19-55	NAME OF CEMETERY OR CREMATORIUM Oak Grove
24. REC'D BY REGISTRAR DATE Dec. 16, 1955		REGISTRAR'S SIGNATURE C. Harry Teller	LOCATION (City, town, or county) Elmwood, Howard, Md.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Foster A. Height, Sykesville, Md.			

BUREAU V. S.

DEC 26

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-51 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11806

11810

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <input checked="" type="checkbox"/> CITY (If outside corporate limits, write RURAL or TOWN and give nearest town)	Carroll	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS 1101 54th Street
HOSPITAL OR INSTITUTION OR STREET ADDRESS <input checked="" type="checkbox"/>	Henryton	lyr. 6mos. 9 das.	Deanwood Park (If rural give location)
Henryton State Hospital			
3. NAME OF DECEASED (First) Joseph (Middle) (Last) Robinson		4. DATE OF DEATH (Month) (Day) (Year) 12 16 1955	
5. SEX <input checked="" type="checkbox"/> Male	6. COLOR OR RACE <input checked="" type="checkbox"/> Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <input checked="" type="checkbox"/> Married	8. DATE OF BIRTH 1-2-1892
9. AGE last birthday 63 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Work	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Greenwood, S. Carolina
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Walter S. Robinson		
14. MOTHER'S MAIDEN NAME Alice Hill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Deceased	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <input checked="" type="checkbox"/> IMMEDIATE CAUSE (A) Heart Failure		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) Pulmonary tuberculosis, far advanced			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 7, 1954, to Dec. 16, 1955, that I last saw the deceased alive on Dec. 16, 1955, and that death occurred at 9:50 P.M. from the causes and on the date stated above. SIGNATURE <i>T.T. Roscoe</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 12/17/55	M.D. NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) Henryton, Md. Washington, D.C.
24. REC'D BY REGISTRAR DATE 12-16-55		REGISTRAR'S SIGNATURE <i>Albert R. Smetham</i>	25. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons ADDRESS 467 N St. NW Wash. H.C.

W.K. 2011-07-11: 1st generation (W.D.H.)

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11771

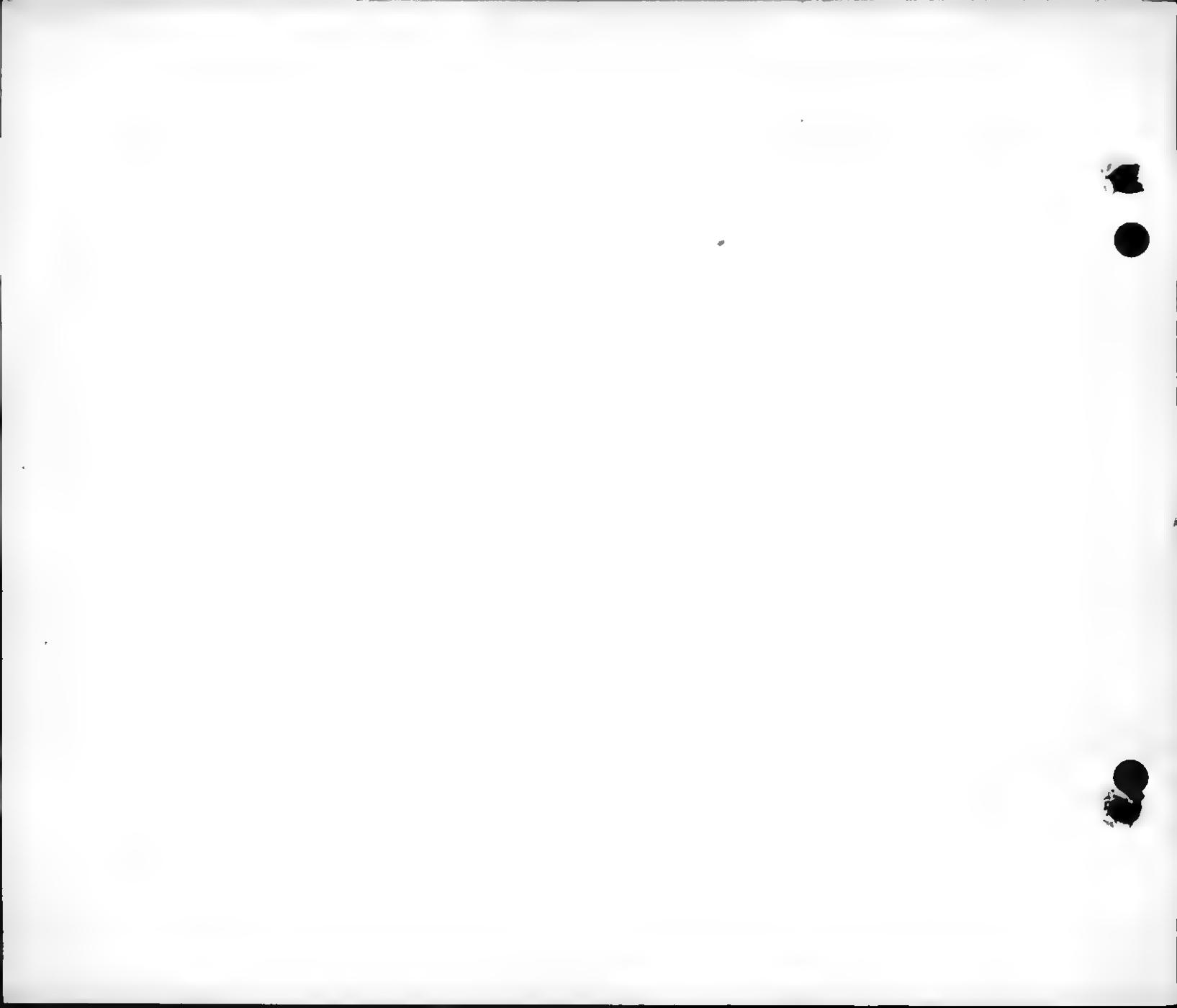
CERTIFICATE OF DEATH

11807

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	COUNTY WESTMINSTER (If rural give location)
27 CARROLL WESTMINSTER H3E. MAIN	62 YRS	MD. WESTMINSTER H3E. MAIN	CARROLL
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH	
VOLA AGNES RUPPERT		DEC. 3 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH
F	W	MARRIED	JULY 28 1893
9. AGE (at birthday yrs.)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
62		HOUSEWIFE	MD.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U.S.A.		RICHARD ARNOLD	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES?	
LAURA TANNER		No	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
215-18-1372		43 E main JOSEPH A. RUPPERT Westminster MD.	
18. MEDICAL CERTIFICATION			
59 X IMMEDIATE CAUSE (A) Chronic Valvular Heart Disease 1945			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension & chronic nephritis 10-15 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 3, 1955</u> to <u>Dec 3, 1955</u>, that I last saw the deceased alive on <u>Dec 3, 1955</u>, and that death occurred at <u>Westminster</u>, from the causes and on the date stated above.			
SIGNATURE			
ADDRESS (Street, city, town, state)			
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		12-7-1955	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIUM	
		ST. JOHNS CEMETERY	
DATE		LOCATION (City, town, or county)	
12-7-1955		Westminster MD.	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
H. BANFIELD & SON		ADDRESS	
WESTMINSTER MD.			





INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11809

11812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	COUNTY RURAL WESTMINSTER X R.D. 6
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) DEATH 12 - 12 - 55	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify	8. DATE OF BIRTH 6-2-1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS INDUSTRY	9. AGE last birthday 85 yrs.
13. FATHER'S NAME DANIEL SCHERER		11. BIRTHPLACE (State or foreign country) MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Not) NO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. NINE		17. INFORMANT & ADDRESS ELLA Z. FAIRNET, FREDERICK, MD.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Thrombosis ANTECEDENT CAUSE(S) DUE TO Arteria Sclerotic Cardis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Renal Disease			
INTERVAL BETWEEN ONSET AND DEATH Few minutes.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 10, 1955, to May 11, 1955, that I last saw the deceased alive on May 10, 1955, and that death occurred at 5:00 AM, from the causes and on the date stated above. SIGNATURE William Scherer M.D. ADDRESS (Street, city, town, state) Westminister DATE SIGNED 12-12-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-14-1955 NAME OF CEMETERY OR BURNAWAY Mt. Olivet	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11810

11813

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (In this place) 10 mo		STATE CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN STREET ADDRESS		COUNTY Baltimore City (If rural give location) 2307 Aisquith St.	
Carroll				Md			
X Sykesville				Baltimore City			
Springfield State Hospital				2307 Aisquith St.			
3. NAME OF DECEASED (Type or Print) James Thomas Schiller				4. DATE (Month) (Day) (Year) Dec. 17 1955			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) wid.	8. DATE OF BIRTH Nov. 1863	9. AGE last birthday 92	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store owner		10b. KIND OF BUSINESS OR INDUSTRY cigar store		11. BIRTHPLACE (State or foreign country) Wilmington Delaware, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Schiller				14. MOTHER'S MAIDEN NAME Margaret Dunbar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk		16. SOCIAL SECURITY NO. 220-07-70124		17. INFORMANT & ADDRESS Records of Springfield State Hosp.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 453 IMMEDIATE CAUSE (A) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (B) generalized arteriosclerosis		more than 10 mo			
		DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. psychosis with senile brain disease				more than 10 mo			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Sykesville, Md.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 2, 1955, to Dec. 17, 1955, that I last saw the deceased alive on Dec. 17, 1955, and that death occurred at 10:48 M, from the causes and on the date stated above. SIGNATURE Martin Gross, M.D. Martin Gross, M.D. M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-21-55		NAME OF CEMETERY OR CREMATORIUM Overbrook		LOCATION (City, town, or county) Brierton, N. J.	
24. REC'D BY REGISTRAR DATE Dec. 18/1955		REGISTRAR'S SIGNATURE C. Harry Weir		25. FUNERAL DIRECTOR'S SIGNATURE H. Schindler Son, Northway & Broadway Brierton, N. J.		ADDRESS	

DEC
1975

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC -53 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

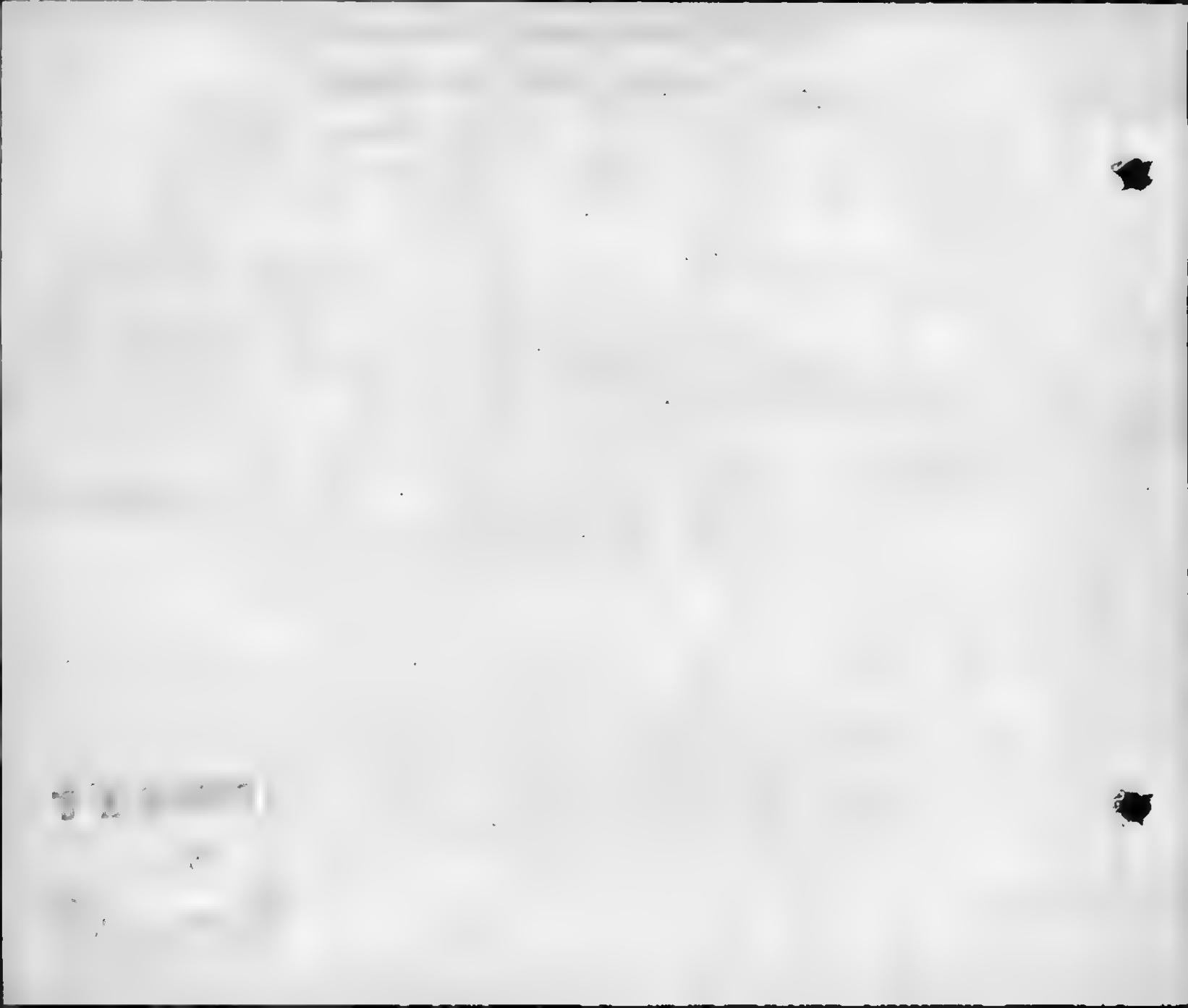
11814

CERTIFICATE OF DEATH

11811

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Carroll		MARYLAND		STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL or end give nearest town) X TOWN Rural - Sykesville		LENGTH OF STAY (in this place) 5Y, 1M, 12 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS 301 South Monroe Street		(If rural give location)	
3. NAME OF DECEASED (First) Albert (Middle) George (Last) SEITLER			4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1955		
5. SEX Male	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	B. DATE OF BIRTH 12/9/04	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper in shipping dept.			10b. KIND OF BUSINESS OR INDUSTRY utilities	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leo Seitler			14. MOTHER'S MAIDEN NAME Rebecca Cromwell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unknown			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS Record, Springfield State Hospital					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 154X IMMEDIATE CAUSE Carcinoma of rectum with metastases to liver			18. MEDICAL CERTIFICATION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) (B) (C) 		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Colostomy performed Involutional psychotic reaction			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years +		
19e. DATE OF OPERATION 11/15/55		19b. MAJOR FINDINGS OF OPERATION Parent lesion in rectum: liver studded with CA		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) 	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. AM. PM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10/20, 1955, to 12/1, 1955, that I last saw the deceased alive on 12/1, 1955, and that death occurred at 8:10AM, from the causes and on the date stated above.					
SIGNATURE Albert Seitler M.D. ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/1/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/6/55		NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery	
24. REC'D BY REGISTRAR DEU		REGISTRAR'S SIGNATURE C. Barry Hayes		LOCATION (City, town, or county) Baltimore (State) MD	
DATE 12/1/55				25. FUNERAL DIRECTOR'S SIGNATURE J. J. Farley Son	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 TOW

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11815

CERTIFICATE OF DEATH

12556

Reg. Dist. No. 6

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN STREET ADDRESS (If rural give location)
CARROLL RURAL HAMPSTEAD	MARYLAND R.D. 1	MD. RURAL HAMPSTEAD	CARROLL R.D. 1
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) MURRAY RITTER SLAGLE (Middle) (Last)		12 28 1955	
5. SEX M	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Specify: WIDOWED	8. DATE OF BIRTH 7-7-1885
9. AGE last birthday 70 yrs.	10. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (State or foreign country) P.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MARTIN L. SLAGLE	14. MOTHER'S MAIDEN NAME not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO	16. SOCIAL SECURITY NO. 220-18-1593	17. INFORMANT & ADDRESS Martin L. Sagle 12-15-1 Hampstead, Md.	INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. ago
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Coronary Thrombosis		ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Old coronary thrombosis	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. ADDRESS (Street, city, town, state)	
22. I hereby certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>55</u> , to <u>Dec. 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 10</u> , 19 <u>55</u> and that death occurred at <u>Hampstead</u> , from the causes and on the date stated above. SIGNATURE <u>M. C. Porter, Jr.</u> DATE SIGNED <u>12/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 12-31-1955	NAME OF CEMETERY OR CREMATORIUM KRIDER'S CEM.	LOCATION (City, town, or county) WESTMINSTER, MD.
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Harriet J. Miller	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hampstead Bankard Son Westminster, Md.	
DATE 1-2-56			



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11812

11816 CERTIFICATE OF DEATH

Reg. Dist. No. 74

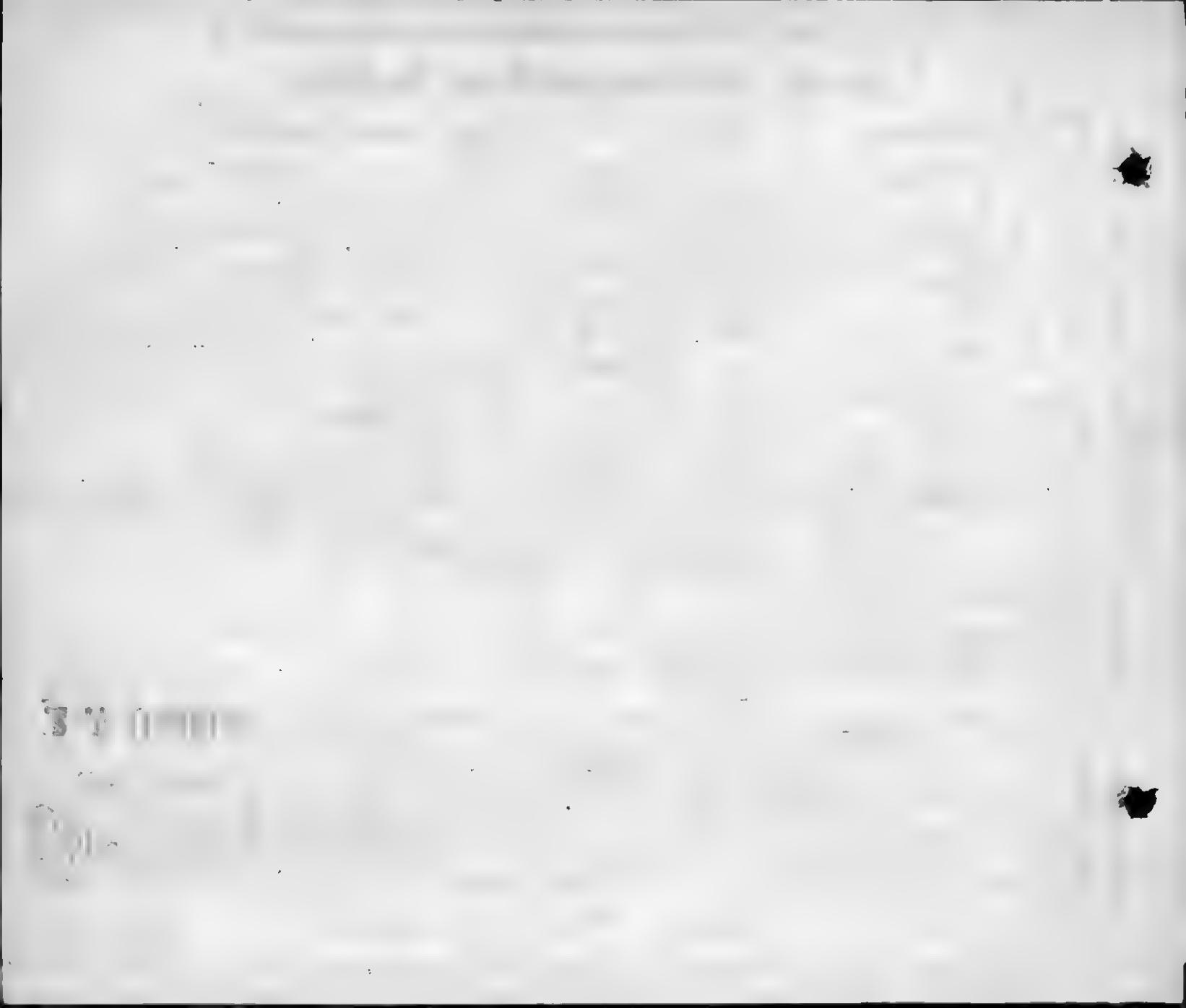
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Carroll MARYLAND		STATE Maryland COUNTY _____	
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (in this place)	TOWN Baltimore City	CITY (If outside corporate limits, write RURAL and give nearest town)
RURAL - Sykesville since 7-13-55			STREET ADDRESS 19 E. Centre Street, Baltimore-2 (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	15 Springfield State Hospital		
3. NAME OF DECEASED (Type or Print)		(First) George	(Middle) Washington
		(Last) SPANGLE	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced	8. DATE OF BIRTH July 9, 1882
9. AGE less birthday yrs. 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) printer	10b. KIND OF BUSINESS OR INDUSTRY printing	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? United States	13. FATHER'S NAME James Spangle		
14. MOTHER'S MAIDEN NAME unknown to us			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unknown
16. SOCIAL SECURITY NO. unknown			17. INFORMANT & ADDRESS Records of Springfield State Hospital
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) CEREBRAL ARTERIOSCLEROSIS- ENCEPHALOMYLACIA DUE TO ARTERIOSCLEROSIS 2 July ANTECEDENT CAUSE(S) DUE TO R. HEMIPLEGIA. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DIABETES. STATING UNDERLYING CAUSE LAST. DUE TO CHRONIC BRAIN SYNDROME ASSOCIATED WITH ARTERIOSCLEROSIS years years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) _____ (State) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from Nov. 28th, 1955, to December 5 1955, that I last saw the deceased alive on 12-3 1955, and that death occurred at 11 A.M. from the causes and on the date stated above.			
SIGNATURE <i>John Padkey, M.D.</i>	ADDRESS (Street, city, town, state) Sykesville, Maryland		DATE SIGNED 13/13/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY) removal	DATE THEREOF 12/6/55	NAME OF CEMETERY OR CREMATORIAL Coalport	LOCATION (City, town, or county) Coalport, Pennsylvania (State)
24. REC'D BY REGISTRAR DATE 15/6/55	REGISTRAR'S SIGNATURE <i>C. Harry Davis</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Jr.</i>	ADDRESS 1217 St. Paul Street



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

11817 CERTIFICATE OF DEATH

Reg. Dist. No.....

Items 10a, 11, 13, 14 Film G190 12-23-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Carroll	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporal limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporal limits, write RURAL and give nearest town)	
TOWN Rural - Sykesville	11 days	TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS 421 West 24th Street	(If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) CHARLES	(Middle) MILTON	(Last) SPRING	12/13 1955 (Month) (Day) (Year)
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH
9. AGE last birthday 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S. A.	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Record, Springfield State Hospital
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Cerebral Hemorrhage		24 hours	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis		years	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction		several years	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/2, 1955, to 12/13, 1955, that I last saw the deceased alive on 12/13, 1955, and that death occurred at 9:25 P.M. from the causes and on the date stated above. SIGNATURE Wallace H. Sonnenfeldt M.D. Baltimore			
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial	DATE THEREOF 12/16/55	NAME OF CEMETERY OR CREMATORIAL Baltimore	LOCATION (City, town, or county) E. North Ave.
REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE C. Harry Hess	25. FUNERAL DIRECTOR'S SIGNATURE Paul E. Schenowitz 3615-17 Leibstadt	
DATE	ADDRESS		

32.

11814

MARYLAND STATE DEPARTMENT OF HEALTH

11818

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 70 80

1. PLACE OF DEATH CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) ELMER	(Middle) NEFAEVER	(Last) STAHAIGH	4. DATE OF DEATH 12 15 1955
5. SEX M	6. COLOR OR RACE /	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH 11-1-1914	9. AGE last birthday 41 yrs.	10. under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-12-1464	17. INFORMANT		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>Immediate cause (a) Gunshot wound of Abdomen</p> <p>Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</p> <p>(c)</p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street OF office, etc.) INJURY House		(CITY OR TOWN) (COUNTY) (STATE) Baltimore County Md	
TIME (Month) (Day) (Year) (Hour) OF INJURY 12 12 55 10P m.		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? Shot with shot gun	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE James J. March		(Degree or title) ADDRESS Deputy Medical Examiner		DATE SIGNED 12/13/55	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 15-1-55		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) LOCATION (State)	
DATE REC'D BY LOCAL REG. REC'D BY LOCAL		REG. REC'D BY LOCAL		REGISTRAR'S SIGNATURE Ethel M. Meharry	
24. FUNERAL DIRECTOR				ADDRESS	

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

11815

11819

2411 N. Charles Street, Baltimore

Reg. Dist. No. 71

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Carroll			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Carroll		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frizzleburg		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print)		(First) Margaret	(Middle) Savilla	(Last) Stevenson	4. DATE OF DEATH Dec. 9, 1955
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH July 13, 1882	9. AGE last birthday 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Augustus Uttermahlen		14. MOTHER'S MAIDEN NAME Annie Wantz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Mr. s Louise Nygren, Frizzleburg, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause		(a) Acute cardiac dilatation			
Antecedent cause(s)		(b) Cardiac Renal Vasculär Disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1951, to Dec. 9, 1955, that I last saw the deceased alive on Dec. 8, 1955, and that death occurred at 5:15 a.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Dec. 11, 1955	NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cemetery	LOCATION (City, town, or county) (State) Pleasant Valley, Maryland	
DATE REC'D BY LOCAL REG. 12/16		REGISTRAR'S SIGNATURE Margaret R. English	24. FUNERAL DIRECTOR C.O. Fuss & Son, Taneytown, Maryland		ADDRESS

BURKARD V. S

JAN 14

LIBRARY USE

11820

CERTIFICATE OF DEATH

Reg. Dist. No. 76

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AIFC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Rural, Westminster 5 days. Westminster RD#5		Maryland Rural, Westminster RD#5	Spring Mills
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
MARY ETTA STEVENSON		Dec. 31, 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
f.	white	Married	Oct. 4, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife			London Co. Va.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jesse Demmitt		Mary Triplett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Mr. John E. Stevenson, M.D., #5 Westminster		Cerebral Hemorrhage Hypertension (old) Myocarditis (old)	
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....			
alive on.....			
SIGNATURE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM
Burial Jan. 3, 1956		Widener Cemetery	Rural, Westminster, Md.
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State)
Hermiet Miller			
DATE		25. FUNERAL DIRECTOR'S SIGNATURE	
Jan. 1, 1956		J. E. Meyers Jr., Westminster, Md.	

July

JAN 4 1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11817

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY TOWN STREET ADDRESS	
X TOWN UNION BRIDGE		years		UNION BRIDGE		UNION BRIDGE (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS STONER ST.				STONER ST			
3. NAME OF DECEASED (First) JOHN W STRAWSBURG (Middle) (Last)				4. DATE OF DEATH DEC 16 1955			
3. SEX M		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M		8. DATE OF BIRTH AUG 8-1892 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIGHT CO				10b. KIND OF BUSINESS OR INDUSTRY POWER HOUSE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN W STRAWSBURG				14. MOTHER'S MAIDEN NAME ELIZABETH HARRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no				16. SOCIAL SECURITY NO. 216-09-0211			
17. INFORMANT & ADDRESS CAROLINE STRAWSBURG UNION BRIDGE				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 597x IMMEDIATE CAUSE (A) CHRONIC NEPHRITIS ANTECEDENT CAUSE(S) DUE TO HIGH BLOOD PRESSURE DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 148516, 1955, to Dec 16, 1955, that I last saw the deceased alive on 12-16, 1955, and that death occurred at 2 P.M., from the causes and on the date stated above. SIGNATURE T. H. LEGG M.D. ADDRESS (Street, city, town, state) Union Bridge DATE SIGNED 12-17-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/18/55		NAME OF CEMETERY OR CREMATORIAL LUTHERAN		LOCATION (City, town, or county) UNIONTOWN MD (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Leslie A. Repp		25. FUNERAL DIRECTOR'S SIGNATURE ODHARTZLER & SONS		ADDRESS UNION BRIDGE	
DATE 12/17/55							

1922-1923 - 1924-1925 - 1925-1926 - 1926-1927 - 1927-1928

MARYLAND STATE DEPARTMENT OF HEALTH

11822

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH: CITY OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE — CITY (If outside corporate limits, write RURAL and give nearest town) TOWN — STREET ADDRESS	
<i>Carroll</i> MARYLAND <i>Hampstead</i>		Md. 1921 Linden Ave 3401-4 <i>Baltimore</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Edith</i>	(Middle) <i>Brown</i>	(Last) <i>Tawney</i>
4. DATE OF DEATH	(Month) <i>Dec</i>	(Day) <input checked="" type="checkbox"/> <i>✓</i>	(Year) <i>1955</i>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH
Female	White	<i>7/16/1913</i>	9. AGE last birthday 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Housework</i>		<i>Own Home</i>	Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Elmer Wesley Brown</i>		<i>Bessie Lee Merriman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>—</i>	<i>Mrs. Don Curtis - Reisterstown Md.</i>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

981X
 Immediate cause (a) *Shot gun Wound*
 Antecedent cause(s) (b) *Neck (Homicide)*
 Diseases or conditions, if any, giving rise to the above causes, stating the underlying cause last (c) *—*

INTERVAL BETWEEN
ONSET AND DEATH*Instant
(none)*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY <i>Gun</i>	(CITY OR TOWN) <i>Hampstead Carroll Md.</i>	(COUNTY) <i>Carroll</i>	(STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Dec 5 1955/12:58 p.m.</i>	INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Homicide</i>		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial See 7-1955 Dover</i>	DATE THEREOF <i>See 7-1955</i>	NAME OF CEMETERY OR CREMATORIAL <i>Dover</i>	LOCATION (City, town, or county) <i>Baltimore County Md.</i>	(State) <i>Md.</i>
DATE REC'D BY LOCAL REG. <i>12/5/55</i>	REG. <i>Ready</i>	REGISTRAR'S SIGNATURE <i>M. P. Manchester</i>	FUNERAL DIRECTOR <i>E.C. Tipton Hampstead</i>	ADDRESS <i>Hampstead Md.</i>

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR
PRINTING

RECEIVED
DEC 12 1955

PUREAU V. S

11819

MARYLAND STATE DEPARTMENT OF HEALTH

11823

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH: COUNTY		Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE		Maryland COUNTY				
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET (If rural, give location)				
TOWN		3 hours.		TOWN		STREET ADDRESS				
HOSPITAL OR INSTITUTION OR STREET ADDRESS				Baltimore		2117 Bolton St.				
3. NAME OF DECEASED (Type or Print)		(First) Paul	(Middle) Homer	(Last) Taylor	4. DATE OF DEATH		(Month) Dec	(Day) 5	(Year) 1955	
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday		If under 1 year Months	Days	Hours	Min.
M		W	MARRIED	Jan 10-1901	54 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY				
Painter			Nurse	Md		USA				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
John Taylor			Mae Wildasin							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		18. MEDICAL CERTIFICATION			
Y			180-01-9909		Jacob Harkenrider, New London Pa					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										
976X										
Immediate cause			(a) Shot Gun Wound							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			(b) of head (Suicide)							
			(c)							
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.										
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?						
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY Gun.		(CITY OR TOWN)		(COUNTY)		(STATE)		
TIME (Month) (Day) (Year)		INJURY OCCURRED OP OF INJURY December 5, 1955		While at work		Not while at work		HOW DID INJURY OCCUR?		
(Hour)		m.		<input type="checkbox"/>		<input checked="" type="checkbox"/>		self inflicted		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .										
SIGNATURE W.H. Ward M.D.		(Degree or title)		ADDRESS		DATE SIGNED 12/15/55				
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 12-8-55		NAME OF CEMETERY OR CREMATORIAL Md Live cemetery		LOCATION (City, town, or county) Md Live		(State) Md		
DATE REC'D BY LOCAL REG.		REG.		FUNERAL DIRECTOR Henry Davis & Son Edw Gipton, Hampstead		ADDRESS				

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

"TEAU V. S.

DEC 12 1965

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11824

11824

CERTIFICATE OF DEATH

Reg. Dist. No 82-83

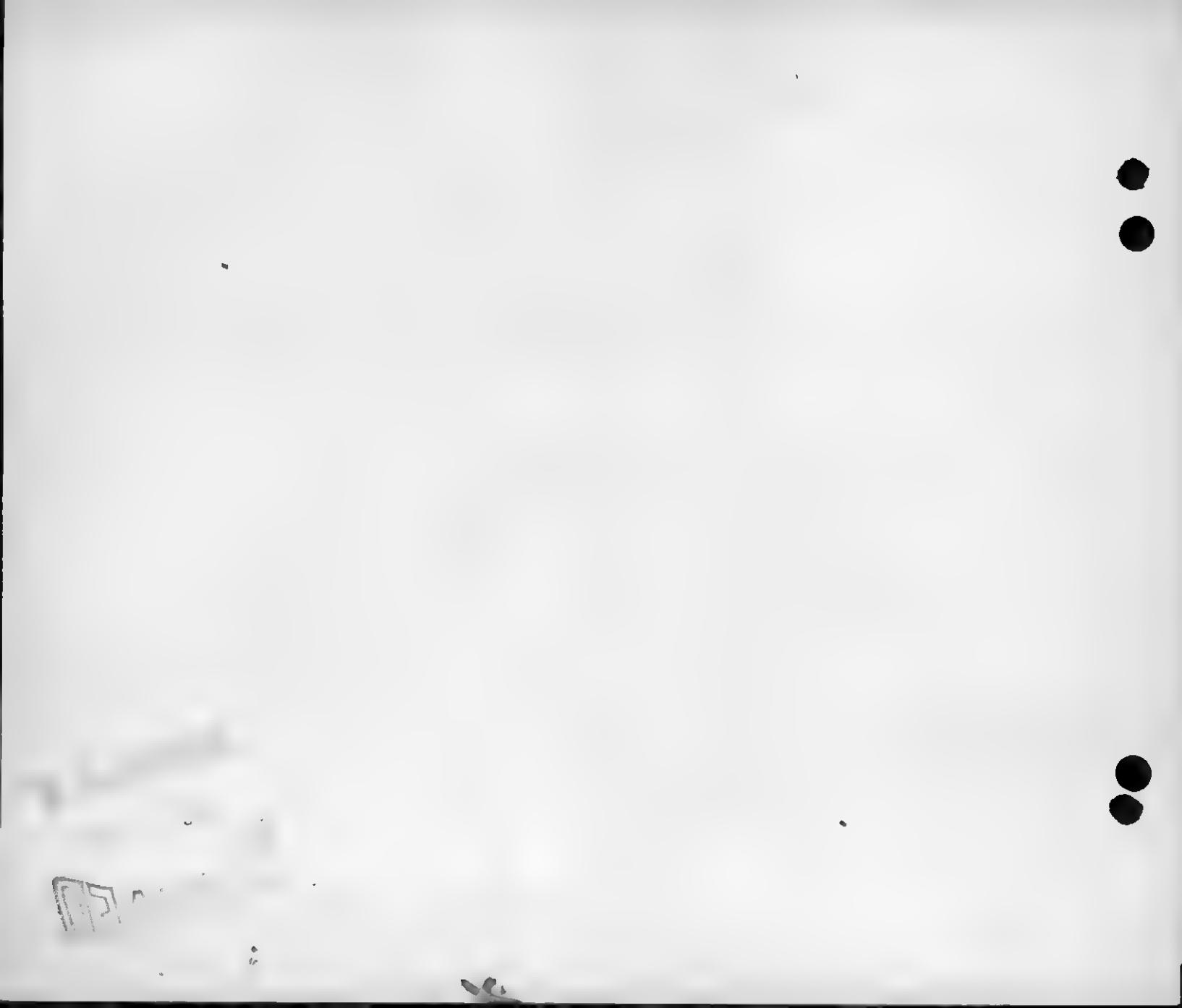
1. PLACE OF DEATH CITY OR TOWN Carroll			2. USUAL RESIDENCE (HOME) OF DECEASED CITY OR TOWN Maryland						
HOSPITAL OR INSTITUTION OR STREET ADDRESS Parrsville			STREET ADDRESS Route 4						
3. NAME OF DECEASED (First) Joanne (Middle) - (Last) Thomas			4. DATE OF DEATH (Month) December (Day) 20 (Year) 1955						
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) -	8. DATE OF BIRTH Aug. 6, 1955	9. AGE last birthday yrs. 4 Months 14 Days 14 Hours 14 Min. 14	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Melvin Dewitt Myers		14. MOTHER'S MAIDEN NAME Ada Mae Thomas		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -				16. SOCIAL SECURITY NO. -	17. INFORMANT AND ADDRESS Mrs. Ada Mae Thomas, Mt. Airy, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Acute Gastro enteritis of undetermined etiology				4 days
Antecedent cause(s)				
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) -				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from December 17, 1955 , to December 18, 1955 , that I last saw the deceased alive on Dec. 19, 1955 , and that death occurred at 8:45 P.m. from the causes and on the date stated above. SIGNATURE W.B. Culwell, M.D. ADDRESS Mt. Airy, Md. DATE SIGNED Dec. 20, 1955				
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--	--	--

23. BURIAL, CREMATION REMOVAL (Specify) 83-1107	DATE 12-22-1955	NAME OF CEMETERY OR Crematory Simpson Chapel	LOCATION (City, town or county) Howard Co. Md. (State)
DATE REC'D BY LOCAL REG. Dec. 22, 1955	REG. Robert R. Hewitt.	24. FUNERAL DIRECTOR ADDRESS Joe M. Katz, Winfield Rd.	



11825

CERTIFICATE OF DEATH

Reg. Dist. No. 75

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Towson</u> TOWN <u>Towson</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> OR TOWN <u>Towson</u> STREET ADDRESS <u>Towson</u>	
3. NAME OF DECEASED: (First) <u>Clara</u> (Middle) <u>Susan</u> (Last) <u>Tracy</u> (Type or Print)		4. DATE OF DEATH: (Month) <u>Dec</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 28 1879</u>
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>nd</u>	11. BIRTHPLACE (State or foreign country): <u>nd</u>
13. FATHER'S NAME: <u>Henry J Werner</u>		14. MOTHER'S MARRIED NAME: <u>Suzanne Sternen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.: <u>219-05-64678</u>	
17. INFORMANT & ADDRESS: <u>A. Parker Tracy Towson, md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>422.0</u> Immediate cause (a) ... <u>Arteriosclerotic Heart Disease</u> Antecedent causes (s) (b) ... <u>Arrhythmic fibrillation</u> Diseases or conditions, if any, giving rise to the above cause (c) ... <u>Congestive Heart Failure</u> stating the underlying cause last.			
Interval Between Onset And Death			
2 yrs			
1 mos			
2 days			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
Signature <u>W.H. Board</u> Degree or title <u>M.D.</u> ADDRESS <u>Manchester, Md</u> DATE SIGNED <u>12/21/1955</u>			
22. I hereby certify that I attended the deceased from <u>Dec 25</u> , 1955, to <u>Dec 21</u> , 1955, that I last saw the deceased alive on <u>Dec 21</u> , 1955, and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W.H. Board</u> (Degree or title) <u>M.D.</u> ADDRESS <u>Manchester, Md</u> DATE SIGNED <u>12/21/1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/24/55</u>	NAME OF CEMETERY OR CREMATORIAL <u>Zion's Chapel Cemetery</u> LOCATION (City, town, or county) (State) <u>Towson, Carroll, Md.</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. H. H. Deamer</u>	24. FUNERAL DIRECTOR ADDRESS <u>H. Sciffle & Son Glen Rock, Pa.</u>
Dec 22-55			

BUREAU Y. A.

1955 EC

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10.W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11822

11826

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Carroll MARYLAND		STATE Maryland COUNTY _____	
CITY [If outside corporate limits, write RURAL OR TOWN Rural - Sykesville LENGTH OF STAY (in this place) since 8-30-26]		CITY [If outside corporate limits, write RURAL and give nearest town] OR TOWN Baltimore City STREET ADDRESS unknown (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital			
3. NAME OF DECEASED (First) Justi (Middle) - TUHOMEN (Last)		4. DATE OF DEATH December 3 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME unknown		11. BIRTHPLACE (State or foreign country) Finland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unk.] no [If Yes, give war or dates of service] unknown		14. MOTHER'S MAIDEN NAME Ida Tuhomem	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Records of Springfield State Hospital	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Lobar pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) _____ (C) _____			
INTERVAL BETWEEN ONSET AND DEATH 4-5 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Hebephrenic schizophrenia more than 29 yrs.			
19a. DATE OF OPERATION 0	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) --- M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 1st, 1947, to Dec. 2nd, 1955, that I last saw the deceased alive on Dec. 2nd, 1955, and that death occurred at 10:30A.M. from the causes and on the date stated above. SIGNATURE Martin Gross, M.D. ADDRESS (Street, city, town, state) Greene St. DATE SIGNED 12/5/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 45 MILE TUBE UFC 6-07 U OF M. MED SCHOOL		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE Dec. 8, 1955		REGISTRAR'S SIGNATURE C. Harry Thur ADDRESS	
		25. FUNERAL DIRECTOR'S SIGNATURE D. J. Duffel, Bus 1800 E Lombard St.	

Y.S.



11823

MARYLAND STATE DEPARTMENT OF HEALTH

11827

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 8d

1. PLACE OF DEATH COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MARYLAND</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>New Windsor Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>New Windsor Rural</i>	
LENGTH OF STAY (In this place) <i>Years</i>		STREET (If rural, give location) ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <i>PAUL</i>	(Middle) <i>BROWN</i>	(Last) <i>WAGNER</i>
4. DATE OF DEATH	(Month) <i>Dec</i>	(Day) <i>25</i>	(Year) <i>1955</i>
5. SEX	6. COLOR OR RACE <i>M W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>Dec 1. 1893</i>
9. AGE last birthday Months <i>62</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Produce Dealer</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Jonas M Wagner</i>	14. MOTHER'S/MARSEN NAME <i>Eta Brown</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT AND ADDRESS <i>Mrs Norman Condon New Windsor</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p><i>Initials</i> Immediate cause <i>Suffocation - Aspirated fish</i> minutes</p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Hypertensive arteriosclerotic C.V disease</i> year</p> <p>(c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, of office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>12 25 1955</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <i>Aspirated fish</i>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that the deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <i>James J. Grans</i>		(Degree or title) <i>Deputy Medical Examiner</i>	DATE SIGNED <i>Washington Md 12/28/55</i>
23. SPECIAL CREMATION METHOD (Supply)	DATE THEREOF <i>12 28 55</i>	NAME OF CEMETERY OR CREMATORIAL <i>Lake Creek</i>	LOCATION (City, town, or county) (State) <i>Carroll Md</i>
DATE REC'D BY LOCAL REG. <i>Dec 28</i>	REGISTAR'S SIGNATURE <i>James J. Benedict</i>	24. FUNERAL DIRECTOR ADDRESS <i>W. Hartman & Son - New Windsor, Md</i>	

Levi & V. S.

250

250

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed, file in by the funeral director, the third copy of this death certificate should be retained for use in funeral transit permit.

VS AISC 1-S5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11824

11772 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	MARYLAND LENGTH OF STAY (in this place) <i>by year</i>	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Westminster 27 (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Carroll County Home</i>	STREET ADDRESS <i>Carroll Co. Home</i>				
3. NAME OF (First) <i>Marshall</i> (Middle) <i>Wetzel</i> (Last)	4. DATE (Month) (Day) (Year) OF DEATH <i>Dec. 5 1955</i>				
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Mar. 1 1875 80 yrs.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	11. BIRTHPLACE (State or foreign country) Md.		
13. FATHER'S NAME <i>Hezekiah Wetzel</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS <i>Mrs Oliver Ellings-Woodbury</i>		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 14.1 IMMEDIATE CAUSE (A) <i>Exhaustion</i> ANTECEDENT CAUSE(S) DUE TO <i>asbestosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE 14.2.1 (B) <i>asbestosis</i> STATING UNDERLYING CAUSE LAST DUE TO <i>?</i> 14.2.2 (C) <i>?</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>He had gangrene in foot</i> 14.2.3 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 14.2.4 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <i>Progressive many yrs</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)		(County)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		(State)
22. I hereby certify that I attended the deceased from <i>10-32, 1949, to 12-5, 1955</i>, that I last saw the deceased alive on <i>12-4, 1955</i>, and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.					
SIGNATURE <i>W. C. Stow</i> M.D. <i>Westminster</i> DATE SIGNED <i>12-5-55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-8-55</i>	NAME OF CEMETERY OR Crematory <i>Brandenburg</i>	LOCATION (City, town, or county) <i>Burwell, Carroll, Md.</i> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Stow</i> ADDRESS <i>Westminster - N. Main - Sylvanville, Md.</i>		
DATE <i>12-8-55</i>					

DEC 19

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AIFC 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11825

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (in this place) 1 mo. 29 days	STATE Maryland CITY TOWN STREET ADDRESS	COUNTY Montgomery CITY TOWN Silver Spring (If rural give location) 10000 Markham Street
Carroll Rural - Sykesville Springfield State Hospital			
3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Elmore (Last) WIBLITZHOUSER		4. DATE OF DEATH 12 13 19 55	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12/24/89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE last birthday 65 yrs.
		11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Dalton		14. MOTHER'S MAIDEN NAME Nellie Dalton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 44-6-1234	17. INFORMANT & ADDRESS Record, Springfield State Hospital
		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		Arteriosclerotic cardiovascular disease Generalized arteriosclerosis	
		INTERVAL BETWEEN ONSET AND DEATH years	
		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction		8 months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
M.			
22. I hereby certify that I attended the deceased from 10/11....., 19...55.., to 12/13....., 19...55., that I last saw the deceased alive on 12/12....., 1955....., and that death occurred at 1:00A.M. from the causes and on the date stated above.			
SIGNATURE Walter St. Johnenfeldt		ADDRESS (Street, city, town, state) Sykesville, Maryland DATE SIGNED 12/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/15/55	NAME OF CEMETERY OR CREMATORIAL Arlington
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE C. Harry Warner	LOCATION (City, town, or county) Arlington Va (State)
DATE Dec 13 1955		25. FUNERAL DIRECTOR'S SIGNATURE Warren E. Cunningham 8434 Ga Ave Sel Sp.	

EC 5 1955

CONFIDENTIAL

V. A.

11829

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. No. 11826
No 82/83

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

I. PLACE OF DEATH:

COUNTY Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
X TOWN rural--Mt. AiryLENGTH OF STAY
(in this place)
8 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN rural--Mt. Airy

STREET ADDRESS Mt. Olive

(If rural, give location)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED:
(Type or Print) BENJAMIN

(Middle)

(Last)

4. DATE
OF
DEATH

DEC. 11,

1955

5. SEX:
male6. COLOR OR
RACE:
white7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widowed8. DATE OF BIRTH:
1875 ?9. AGE last birthday:
80 ? yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired) Chair maker10b. KIND OF BUSINESS OR
INDUSTRY:
self-employ11. BIRTHPLACE (State or foreign country):
Va.12. CITIZEN OF WHAT
COUNTRY?
U.S.

13. FATHER'S NAME:

Elias Wines

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)
NO16. SOCIAL SECURITY NO.:
none17. INFORMANT & ADDRESS:
Mrs. Fannie Tinsman, Mt. Airy, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

18. MEDICAL CERTIFICATION

Immediate cause

(a)...
DUE TO

Coronary disease

INTERVAL BETWEEN
ONSET AND DEATH

4 hours.

Antecedent cause(s)

Diseases or conditions, if any, (b)...
giving rise to the above cause DUE TO
stating underlying cause last (c)

arterial sclerosis

several years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

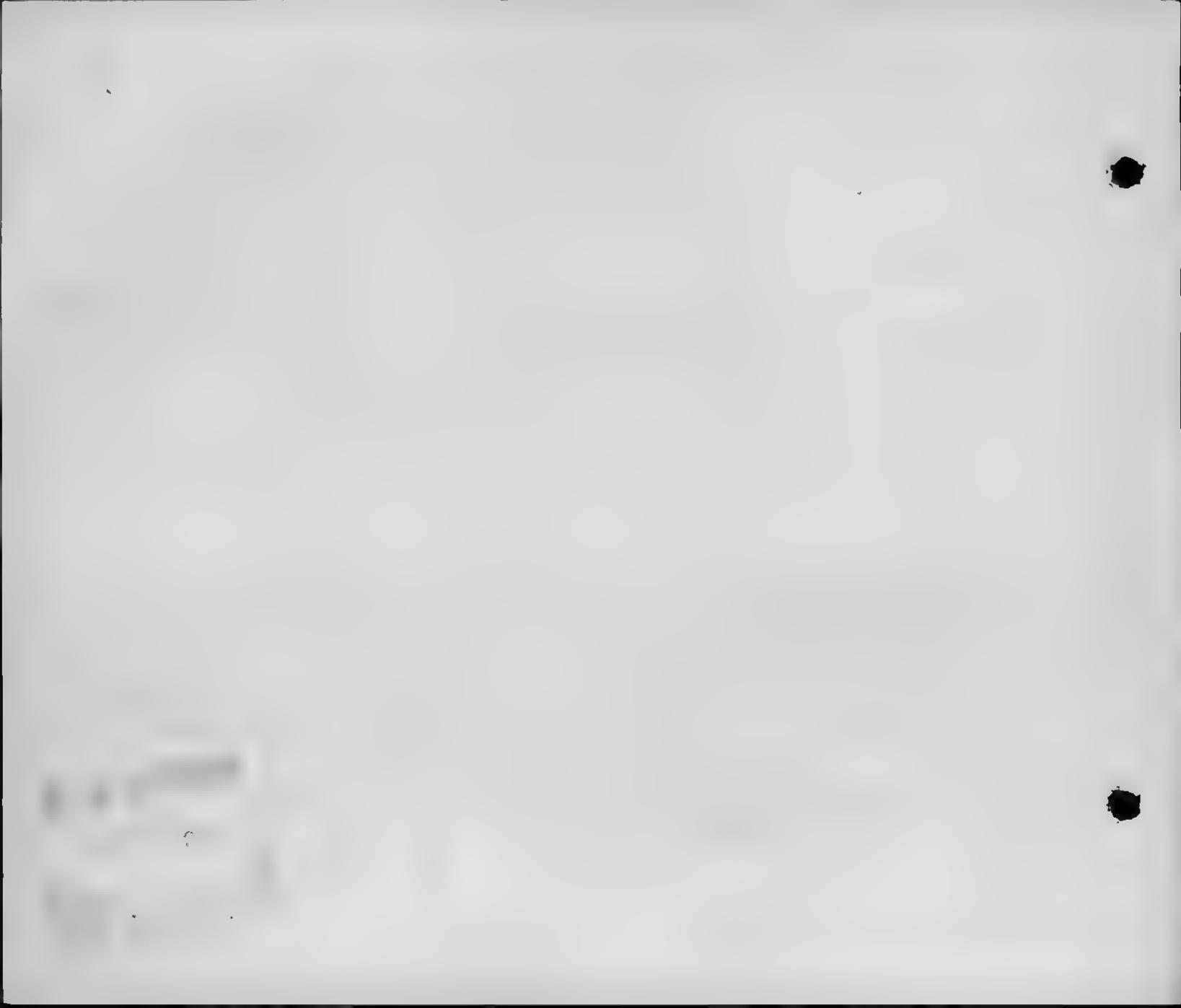
20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH. 21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY) 21c. (City or town) (County) (State)21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED
OF While at Not while
INJURY M. work at work 21f. HOW DID INJURY OCCUR?22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .
SIGNATURECHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

12/11/55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
REMOVAL (Specify): BURIAL 12-14-1955 Greenhill Berryville, Va.DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
Dec. 13, 1955 Robert P. Hewitt, J. M. Waltz, Winfield, Md.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AFSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11827

11830 CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY MARYLAND UNION BRIDGE (If rural give location)
CARROLL UNION BRIDGE	YEARS	UNION BRIDGE	CARROLL
HOSPITAL OR INSTITUTION OR STREET ADDRESS BENEDUM ST.	BENEDUM ST.		
3. NAME OF DECEASED (First) M. (Middle) ANNIE (Last) YINGWING	4. DATE OF DEATH DEC. 27 1955		
SEX F	COLOR OR RACE W	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	DATE OF BIRTH Oct. 24-1866
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ELI HANN	14. MOTHER'S MAIDEN NAME DEBORAH STEM		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) N	16. SOCIAL SECURITY NO. NCNE	17. INFORMANT & ADDRESS MRS. WILBUR FOWBLE UNION BRIDGE, MD	INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
18. MEDICAL CERTIFICATION			
19. IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	Chronic Myocarditis Atherosclerosis		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 23 1955, to Dec. 27 1955, that I last saw the deceased alive on Dec. 26, 1955, and that death occurred at 12 PM from the causes and on the date stated above. SIGNATURE J. H. Legg M.D. ADDRESS Union Bridge DATE SIGNED 12-28-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF DEC 30 1955	NAME OF CEMETERY OR CREMATORIUM Mt. View Cem.	LOCATION (City, town, or county) UNION BRIDGE, MD (State)
24. REC'D BY REGISTRAR DATE Dec. 29 1955 Leslie Keph	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DR. HARTZLER & SONS UNION BRIDGE, MD	



11831

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 11828

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

I. PLACE OF DEATH:

COUNTY Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Sykesville Md.

LENGTH OF STAY
(In this place)
29 yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS
10. Springfield State Hosp.3. NAME OF
DECEASED:
(Type or Print)

(First) Bertie

(Middle) S.

(Last) Youngman

4. DATE
OF
DEATH

(Month) 12

(Day) 10

(Year) 1955

5. SEX:

6. COLOR OR
RACE: W7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): S8. DATE OF BIRTH:
? ?9. AGE last birthday:
66 yrs.IF UNDER 1 YEAR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):10b. KIND OF BUSINESS OR
INDUSTRY:11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT
COUNTRY? U.S.A.

13. FATHER'S NAME:

William Youngman

14. MOTHER'S MAIDEN NAME:

Laura Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

Hospital Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

917.7

Immediate cause

(a) Due to Acute Shock

INTERVAL BETWEEN
ONSET AND DEATH
min.

Antecedent cause(s)

260+ Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) Due to

(c) Diabetes

260+

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE Schizophrenic Reaction paranoid
DISEASE OR CONDITION CAUSING DEATH type

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes No 21a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY Dec 10 1955 2 P.M.21b. PLACE (Home, farm, factory,
of street, office bldg., etc.)
INJURY Hospital21e. INJURY OCCURRED
While at Not while
work at work

21c. (City or town)

Sykesville Carroll Maryland

(County)

(State)

21f. HOW DID INJURY OCCUR?

Burned by hot water in tub

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

Signature J. H. Harsh

CHIEF MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

12/10/55

23. BURIAL, CREMATION,
REMOVAL (Specify): Burial

DATE REC'D BY LOCAL REG.

Dec. 11, 1955

DATE THEREOF 12-13-55

REGISTRAR'S SIGNATURE C. Harry Green

ADDRESS

J. O. Mitchell Sons - 1900 Eddy Hwy. Bell,

U.S. AIR FORCE

DEC 10 1967

U.S. AIR FORCE

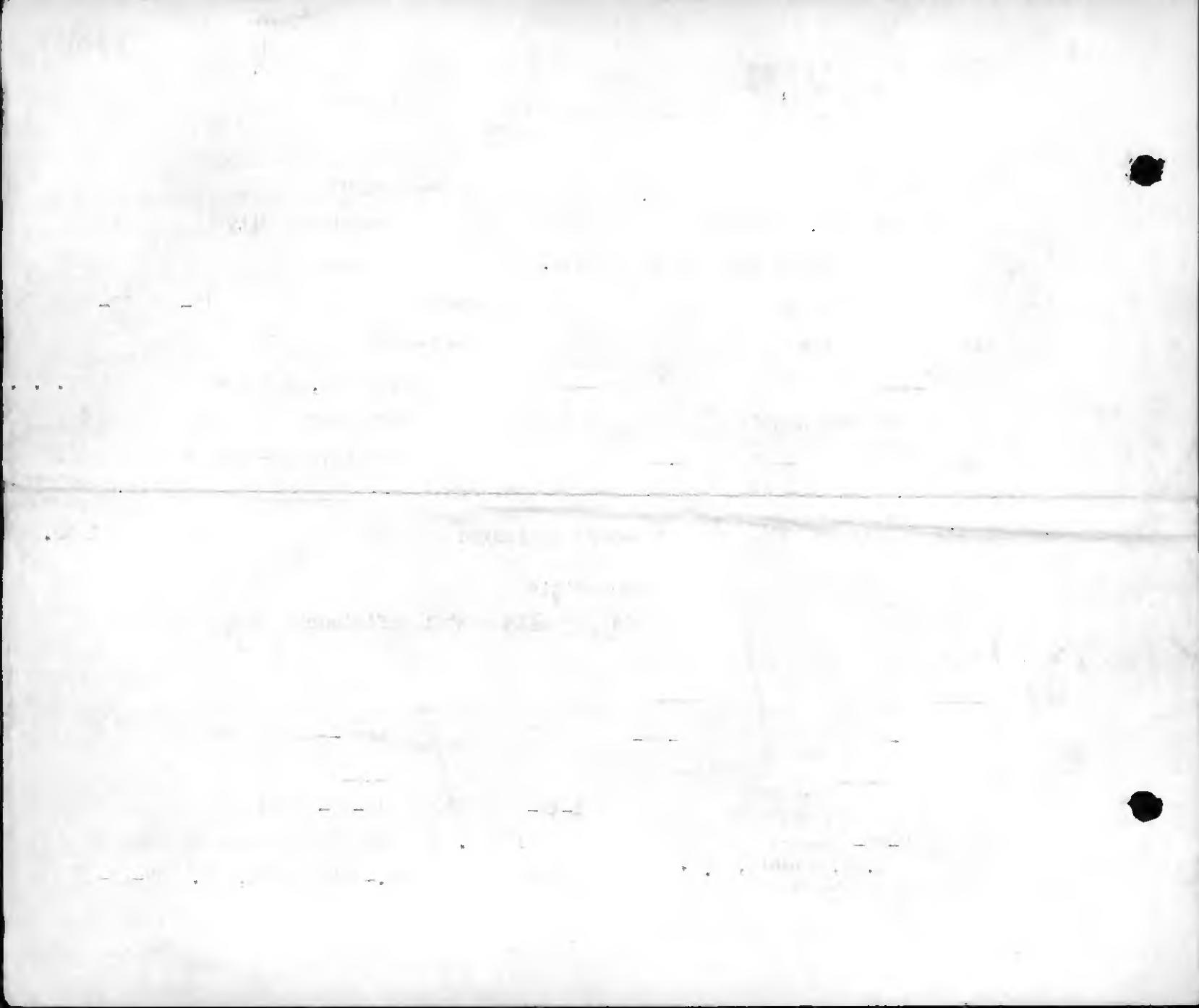
MARYLAND

11832

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Carroll		MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Maryland		LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City STREET ADDRESS ---	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital									
3. NAME OF DECEASED (Type or Print) Alois		(First) (Middle)		(Last) Zephir		4. DATE OF DEATH 12-27-1955		(Month) (Day) (Year)	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single		8. DATE OF BIRTH 3-26-1903		9. AGE last birthday 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---						If under 1 year Months Days Hours Min.	
13. FATHER'S NAME Charles Zephir						11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		14. MOTHER'S MAIDEN NAME Dora Zang		17. INFORMANT AND ADDRESS Hospital records			
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) Coronary occlusion Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocarditis stating the underlying cause last (c) Epilepsy with mental deficiency									
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION ---		19b. MAJOR FINDINGS OF OPERATION ---				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE ---		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY ---		(CITY OR TOWN) ---		(COUNTY) ---			
TIME (Month) (Day) (Year) (Hour) OF INJURY ---		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>		HOW DID INJURY OCCUR? ---		(STATE) ---			
22. I hereby certify that I attended the deceased from 1-12-1942 , to 12-27-1955 , that I last saw the deceased alive on 12-27-1955 , and that death occurred at 9:55 A.m. , from the causes and on the date stated above. SIGNATURE M. N. Martin, M.D. (Degree or title) ADDRESS DATE SIGNED Springfield State Hosp.-Sykesville, Md. 12-27-55									
23. BURIAL/CREMATION REMOVAL (Specify) ---		DATE 12/31/55		NAME OF CEMETERY OR Crematory C.E. H.A.S. Free		LOCATION (City, town, or county) Baltimore			
DATE REC'D BY LOCAL REG. 12-28-55		REGISTRATION SIGNATURE Frederick J. Scott		24. FUNERAL DIRECTOR ADDRESS FUNERAL Homes					



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11830

11833

CERTIFICATE OF DEATH

75

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. This bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been excused by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MDSFC 1-55 10A

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>CARR o 11</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X Manchester</i>	LENGTH OF STAY (In this place) <i>5 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	STREET ADDRESS <i>147 E. Green St.</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Longview Nursing Home</i>			
3. NAME OF DECEASED (First) <i>Ida</i>	(Middle) <i>V.</i>	(Last) <i>Zile</i>	4. DATE OF DEATH (Month) <i>Dec</i> (Day) <i>30</i> (Year) <i>1955</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Dec 21 1859</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE last birthday <i>98</i> YES Months Days Hours Min.
13. FATHER'S NAME <i>Abram Miller</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT & ADDRESS <i>Arthur M. Zile, Westminster Md.</i>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Chronic Hypertension</i>		18. MEDICAL CERTIFICATION <i>Arterio-Sclerotic Cardiovascular Disease</i>	
IMMEDIATE CAUSE <i>Arterio-Sclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
ANTECEDENT CAUSE(S) <i>—</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>—</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>—</i>			
19a. DATE OF OPERATION <i>—</i>	19b. MAJOR FINDINGS OF OPERATION <i>—</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>—</i>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>—</i>	
21d. TIME OF INJURY (Month) <i>Dec</i> (Day) <i>28</i> (Year) <i>1955</i> (Hour) <i>—</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>—</i>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>—</i>		21f. HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>Nov 25, 1955</i>, to <i>Dec 30, 1955</i>, that I last saw the deceased alive on <i>Dec 28, 1955</i>, and that death occurred at <i>11413</i> M., from the causes and on the date stated above. SIGNATURE <i>Joseph V. Bushnell M.D. Hampton Rd.</i> ADDRESS <i>(Street, city, town, state)</i> DATE SIGNED <i>Dec 30, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Jan 2, 1956</i>	NAME OF CEMETERY OR CREMATORIUM <i>Ebenezer Cemetery</i>	LOCATION (City, town, or county) (State) <i>Worfield Carroll Co. Md.</i>
24. REC'D BY REGISTRAR <i>REC'D DAT</i> <i>Dec. 31-55</i>	REGISTRAR'S SIGNATURE <i>Mrs. W.P. Denner</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Meyer Jr. Westminster, Md.</i>	

WISCONSIN STATE DEPARTMENT OF MIGRATION - SAVINWOOD

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 4 1956

REGISTRY